THE THREE R'S:

RECOGNIZING, REACHING, AND REFERRING WOMEN WITH ADDICTIONS

A GUIDE FOR CAREGIVERS

Prepared for the
Women's Policy Office
Government of Newfoundland and Labrador
By:
Ross A. Klein, Ph.D.
Denise Lawlor, M.S.W.
Bonnie Woodland, M.Ed.
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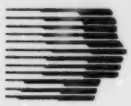

Women's Policy Office
Government of Newfoundland & Labrador
P.O. Box 8700
St. John's, NF
A1B 4J6

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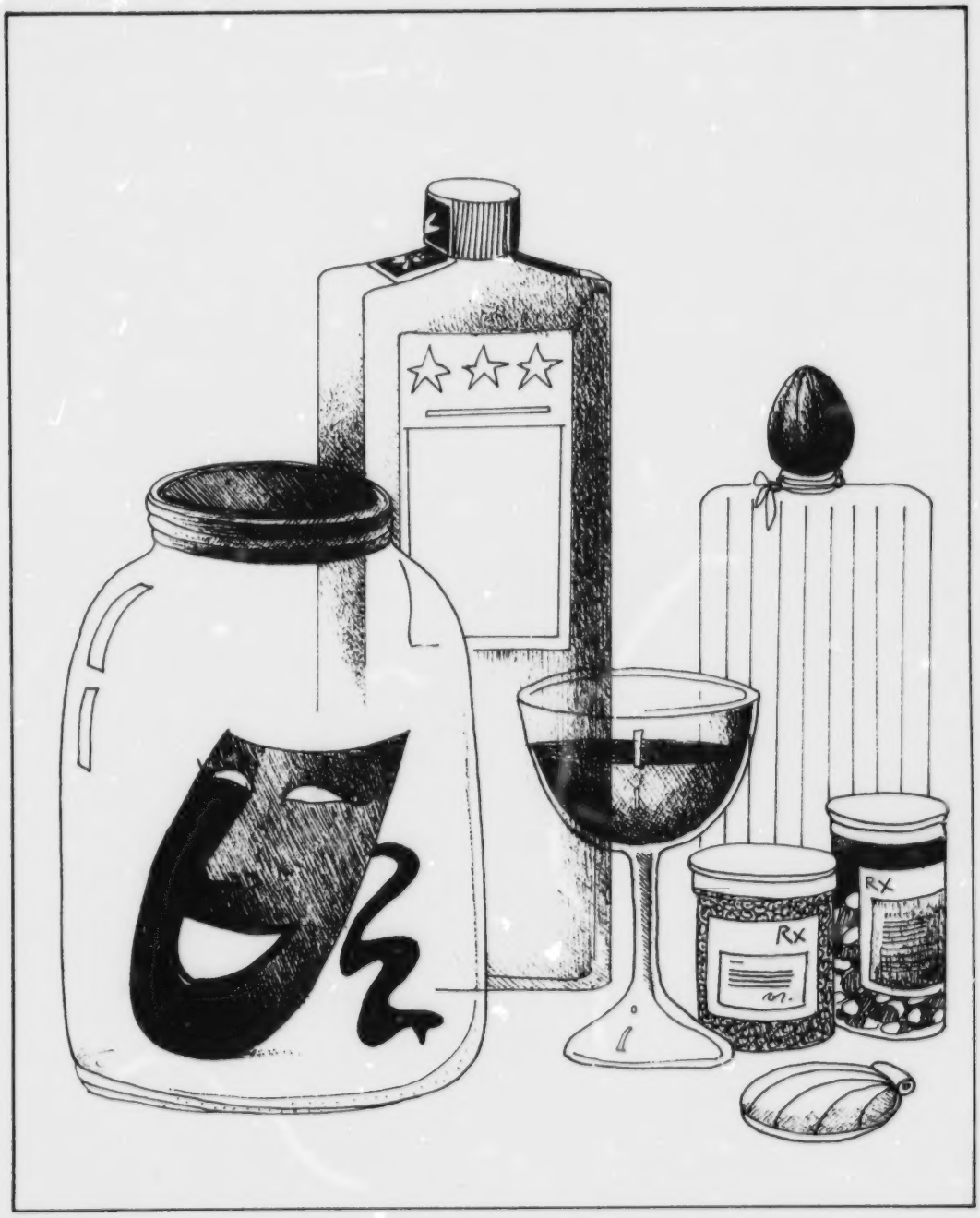
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FOREWORD

Established in 1985, the Women's Policy Office is the staff organization within the Government of Newfoundland and Labrador which coordinates the development of programs and policies for the benefit of women in the province.

The Women's Policy Office is cognizant of the special needs of women with addictions. The idea of producing a manual for professionals was finalized after Skirting the Issue: Treatment Needs of Women with Addictions was published by the Community Services Council of Newfoundland and Labrador in November, 1989. A contract to write the text for the manual was given to three individuals who are well known in their respective disciplines and for their work in the field of addictions.

ABOUT THE AUTHORS:

Ross A. Klein, Ph.D., is Associate Professor of Social Work at Memorial University of Newfoundland. Dr. Klein has fifteen years of experience in social work practice and social work education. In his role as consultant to the Community Services Council, he was involved with a study of treatment needs of women with addictions in Newfoundland. He has been involved in a variety of community studies and community projects.

Denise Lawlor, M.S.W., is in private practice in St. John's. She was previously employed as Director of Addiction Service with Adwise Associates, Inc. For thirteen years she worked in the field of mental health and established the first addictions program for the Waterford Hospital. She has made numerous presentations and workshops at local, regional, national, and international conferences.

Bonnie Woodland, M.Ed., is a research consultant in the areas of health and education and has worked extensively with projects concerned about women's issues. Ms. Woodland served as Project Coordinator for Skirting the Issue: The Treatment Needs of Women with Addictions and has made presentations at regional conferences about women's treatment needs. She has published several articles in Waterlily.

The Women's Policy Office acknowledges the contribution of Beverly Clarke, Director of Program Services, and other staff of the Alcohol and Drug Dependency Commission of Newfoundland and Labrador in providing comments on the draft text and their assistance with publicizing and distributing this manual.

PREFACE

This guide for caregivers is intended for all those who work with and provide help to women. It is meant to be a resource which combines practical and theoretical information in order to help **all** caregivers in recognizing, reaching, and referring women with substance abuse problems.

The guide is written for professionals working in a wide variety of settings and from a broad range of educational backgrounds. It is intended for those who may be considered caregivers and those who provide support services to women. This includes counsellors, physicians, social workers, nurses, clergy, occupational therapists, physical therapists, and lawyers, to name a few.

Women's addictions issues and needs have generally gone unrecognized. There has been limited research in the area. Therefore, most caregivers, including those with advanced graduate degrees, may not have had the opportunity to learn about substance use and abuse issues as they relate to women. This means that the interrelationships between women's lives and the addiction process is something that most caregivers are not as familiar with as they perhaps would like to be.

The purpose of this resource guide is:

- to provide an overview and understanding of women who are experiencing substance abuse problems or who are suffering with an addiction;
- to provide knowledge and understanding about the major issues facing women which are related to the incidence of substance abuse;
- to increase awareness of the ways in which dominant societal values and attitudes act as barriers to identifying women with substance abuse problems;

- to identify guidelines which will help caregivers in developing a strategy for identifying women who are at risk for or who are experiencing an addiction;

- to identify guidelines which will assist caregivers in developing a strategy for referring to appropriate resources women who are at risk for or who are experiencing an addiction;

- to provide an overview of treatment options for women with addictions.

The information provided in this resource guide is gathered from the literature available about women and addictions, from other resource and training manuals, and through contacts with the staff of women's treatment programs throughout North America. In addition, the authors have drawn on direct clinical experience working with women experiencing substance abuse problems in Newfoundland. Our primary focus is on general issues affecting all or most women. We are aware that this manual does not address the addiction issues specifically related to ethnic women, native women, disabled women, and elderly women.

This manual is presented to help you, the caregiver, understand more about women with addictions. It should assist you in knowing how to recognize women with substance abuse problems, how to reach out to them, and where to refer them for needed support and services. The manual also includes a useful Appendix in which other resources are cited (i.e., organizations, treatment programs, and audio visual materials).

INTRODUCTION

WHY DO PROFESSIONALS NEED TO KNOW ABOUT WOMEN AND ADDICTIONS?

> "We generally have the same biases as society; we basically lack an awareness of the problem and generally don't recognize it."
>
> -Physician, St. John's

"*An alcoholic is an alcoholic*" is an often-used cliche in the addictions field. However, the statement is increasingly recognized as a simplistic overview. While there are many similarities between addicts, it is acknowledged that there are many differences between persons with alcohol-related problems and between persons addicted to other substances. Among these differences, sex appears to be among those that are most important, and one that has important implications for treatment and recovery.

Until recently, it was assumed that men's and women's substance abuse problems were fundamentally the same, and that the methods and issues around treatment were the same for men and women. This is not surprising considering the paucity of research about women and substance abuse, and considering the limited attention given women as a separate class of "abuser" or "addict".

Consequently, professionals in all fields tend to have limited knowledge about women's patterns of substance abuse, and about the factors that seem to be related to this abuse. In addition, many have negative stereotypes about women with alcohol-related problems and about women who use drugs. Professionals generally have not learned the necessary skills for identifying

women with addictions. As well, their knowledge about intervention strategies is often limited.

It is important that professionals and para-professionals who are in contact with women with "problems" understand the differences between men and women with addictions and the implications of these differences for identification and treatment. These differences are discussed in detail in the section of this manual concerned with "Recognizing Women with Addictions".

SCOPE OF THE PROBLEM

There are no direct measures of the total number of women and men with addictions (drug or alcohol) in Newfoundland and Labrador. Agencies providing human services, other than addiction treatment agencies, rarely identify or record chemical dependence as a primary problem. Instead it is frequently documented after the fact, in a very general way.

Women and men with addictions are generally under-represented by hospital data. Hospitals, for example, will identify and record some alcohol and drug admissions. Many times, however, substance abuse is an underlying contributing factor to other illnesses, for example cirrhosis, pancreatitis, or depression.

Therefore, there are no reliable statistics on actual numbers of persons with addictions. Available statistics on the prevalence of chemical dependence among men and women rely largely on <u>estimates</u>.

The two most frequently used methods for arriving at estimates of the numbers of persons with addictions use the Jellinek Formula or the General Formula.

Both of these methods indicate that there are between 12,000 and 16,000 alcoholics in Newfoundland and Labrador; roughly one-third (between 4,000 and 5,000) of these are women. However, it is likely that there are many more women and men with addictions than these figures indicate (Woodland, 1989).

Most notably, these estimates do not include individuals who are addicted to drugs other than alcohol. Hospital and treatment program records indicate that addictions to prescription, over-the-counter, and illegal drugs are also significant in number. The severity of the problem as it relates to women is particularly obscured. We know, for example, that women are prescribed mood altering drugs more frequently than are men. In addition, their use of mood altering drugs is more frequent and more regular than men.

FACT SHEET

Some General Facts

Did you know that.....

- Up to 10% of North Americans become alcoholics and a further 10% develop drinking problems (Barrett, 1989).

- Drug addiction and alcoholism cause about 30% of all illnesses in Canada (Addictions Research Foundation, 1984).

- Approximately 10% of all deaths in Canada are alcohol related (Addictions Research Foundation, 1984).

- Between 20 and 25% of all hospital beds are used by alcoholics admitted for medical reasons other than alcohol (Berry and Boland, 1977).

- The overall economic impact of alcohol abuse on the Province of Newfoundland and Labrador in 1988 was estimated to be over $150,000,000 (White, 1988).

- Pain relievers are the most common type of drug taken in Newfoundland (Newfoundland Health Review, 1986).

- Nationally, vitamins are the most frequently taken drug (Newfoundland Health Review, 1986).

FACT SHEET

Some Facts About Women

Did you know that.....

- Health and Welfare Canada estimates that there are more than 189,000 female alcoholics in Canada (Addictions Research Foundation, 1984).

- In a survey in Ontario, 82% of women 18 years of age and older indicated they had used alcohol at least once in the previous year (Addictions Research Foundation, 1984).

- The Canada Health Survey states that 19.4% of women aged 15 years and older used pain relievers in the two days prior to the survey (Addictions Research Foundation, 1984).

- One-third of all identified alcoholics in Canada are women (Health and Welfare Canada, 1981).

- It is estimated that there are 4,000 - 5,000 female alcoholics in Newfoundland (Woodland, 1989).

- In 1980/81 women accounted for 60% of all cases treated for drug related problems in general hospitals in Canada (i.e., drug psychoses, drug dependence, non-dependent abuse of drugs, and poisoning from analgesics, sedatives and hypnotics, and psychotropics) (Addictions Research Foundation, 1984).

- Almost twice as many women as men (15.4% vs. 8.8%) in Newfoundland report using pain relievers (Newfoundland Health Review, 1986).

- 56% of addicted women in recovery, surveyed by a study done in St. John's, reported being addicted to alcohol and other drug(s). Prescription drugs were the most common cross addiction (46%) (Woodland, 1989).

- Only 20% of the professionals interviewed, in a study including physicians, psychologists, and social workers, routinely or directly asked questions to identify women with addictions (Woodland, 1989).

- The death rate is as much as seven times greater for alcoholic women than for women in the general population (Finkelstein et al, 1990).

- 70% of women with addictions have previously been victims of some form of abuse, including physical abuse, sexual abuse, emotional abuse, and combinations of each of these (Wilsnak, 1984).

- Valium is one of the most commonly prescribed drugs in Canada and is prescribed primarily to women (Ings, 1988).

RECOGNIZING

WOMEN WITH ADDICTIONS

One of the greatest challenges facing professionals working with women is being able to recognize when substance abuse problems are present. Professionals are the front line workers who have contact with women. Women often come for help, but rarely identify substance abuse as a problem. In some cases this is because there isn't a substance abuse problem. However, in other cases the problem is there, ready to be asked about. In this section of the manual we discuss the barriers that make it difficult to recognize substance abuse problems, and provide a brief primer on women with addictions.

BARRIERS TO IDENTIFICATION OF WOMEN WITH ADDICTIONS

The Role of Professionals - Not Seeing the Problem

> "We have to know what questions to ask. We have to have the ability to ask them, and we have to know what to do with the information when we get it."
>
> -Family Physician, St. John's

Physicians, nurses, mental health workers, social workers, clergy, probation officers and staff of women's centres are in key positions to identify women with substance abuse problems. However, there are two barriers to the easy identification of problems when they exist.

1. <u>These relationships often do not provide the opportunity for identification that one might think.</u> Unless addressed directly, the woman with an addiction is not likely to provide visible signs of her addiction.

2. <u>Professionals rarely routinely ask questions about substance abuse.</u> For example, over 80% of a sample of 45 professionals participating in a recent study in St. John's, Newfoundland, indicated that they did not routinely ask

about their client's or patient's substance use/abuse. Most reported that they were less likely to ask or confront a female client about her substance use/abuse patterns than they were to ask men. They also indicated that there were fewer occasions where substance use patterns would come up in discussion with female clients/patients than with men (Woodland, 1989).

> "At one point I had to see a gastroenterologist and he asked me every question in the book except about my alcohol intake. This was probably the source of the problem I was having."
>
> -Woman in Recovery, St. John's

The Canadian Medical Association has recently acknowledged the importance of routinely asking patients about any alcohol and drug problems they may have. The CMA has begun publicizing to physicians that addiction prevention comes with daily treatment of every patient: male, female, adolescent and adult.

Other professionals need to follow this initiative. One recommendation in Skirting the Issue: Treatment Needs of Women with Addictions, a 1989 study of Newfoundland and Labrador funded by the Health Promotions Branch of Health and Welfare Canada, suggests that protocol to screen all clients for substance abuse is needed within a variety of social agencies, including hospitals.

The Role of Women Themselves - Concealing the Problem

The identification of women is further complicated by the fact that women with addictions are not likely to seek help specifically for an addiction problem. They are more likely to seek help for a variety of other problems in their lives: depression, anxiety, pain, family problems, relationship problems, health, job-related problems, or other personal problems (Lindbeck, 1972). As pointed out

by Mulford (1977), a female alcoholic may consult a physician or a counsellor for problems that are related to, or have as their source, a drinking or drug related problem. However, she may not identify these problems as being related to her drinking or use of drugs.

Often, because the woman does not perceive use of substances as an issue in itself, she is not likely to disclose her substance use to a professional. In addition, because the professional is primarily concerned about dealing with the physical and/or emotional problems presented, s/he is unlikely to question the woman about her chemical intake (Straussner, 1985).

There are several reasons why a woman may conceal her use of alcohol or drugs, or why her substance use may appear invisible to the helping professional. These reasons include: stigma and guilt, gender role expectations, substance abuse patterns, and denial.

Stigma and Guilt. There are a number of reasons for a woman to feel stigma and guilt when dealing with her own substance abuse problem (see Kinney and Leaton, 1987).

1. Awareness that others are able to control their intake of substances creates a feeling of embarrassment and contributes to a lower self-esteem.

2. A woman who is aware of her drinking or substance abuse problem has in her mind the stereotypes of the alcoholic or addicted woman, stereotypes that have very negative connotations.

Stigma and guilt seem to work in different ways. Stigma causes the woman to have a negative perception of herself as a result of her problem; guilt causes her to blame herself for her problem and to feel responsibility for the problem. Excessive levels of guilt lead to the guilt/substance abuse spiral. For example,

she may feel guilty, so she drinks; in turn, her drinking raises her level of guilt. This is a vicious cycle.

Gender Role Expectations. Society seems to judge the woman with a substance abuse problem more harshly than it does the man with the same problem (Ridlon, 1988). A woman's loss of control and shirking of family responsibility are things that are viewed with concern and quite negatively. The same behaviour on the part of a male is viewed as "letting go", "getting loose", or "taking the time he needs given the pressures of work".

> "When a man gives up [drinking] he is given credit. When a woman gives up we say 'well it's about time'."
>
> -Woman in Recovery, St. John's

The expectations of men and women in society are clearly different. Gender role expectations provide a number of disincentives for women to acknowledge and publicly deal with substance abuse problems (Underhill, 1986).

1. Dominant beliefs and values entrenched in society keep women from seeking help or admitting to having an addiction problem. Women are taught from an early age that their role in society is to take responsibility for the needs of others, and that the needs of others must always be placed before their own needs. To admit that she needs help for a substance abuse problem requires a woman to let go of the feeling of responsibility for those around her. This is particularly difficult when there is responsibility for a spouse, children, and/or elderly parents (Gotlieb, 1980).

2. Women are likely to be enabled to maintain their addiction; they are more likely to be protected. It is less likely that a woman's substance abuse

problem will be identified and addressed by a family. Even when it is identified there is less pressure from within the family to prompt a woman to publicly seek treatment (Mulford, 1977). The family tends to ignore the problem, and protect her if she is unable to fulfill all of her responsibilities.

> "My family didn't want me to get treatment. They didn't think I had a problem. They thought I was nuts or crazy for seeking help."
>
> -Woman in Recovery, St. John's

3. Children present a disincentive to admission by a woman that she has a problem (Beckman et al, 1985). If she admits that she needs help, and is willing to enter treatment, the first question raised is "who will take care of my children?". If married or living near family there may be some reasonable options; she may ask others to take care of her children and/or family during treatment. But this requires her to admit to others that she has a substance abuse problem. This may be easier said than done.

4. The disincentives presented by the presence of children are somewhat different for the single parent (Marshall, 1989). Not only is there the difficulty of finding someone to care for her children, but there is also concern over whether her children will remain with her. Will her former spouse or Child Welfare take steps to remove the children from her care? That fear in itself may inhibit her from admitting that a problem exists.

5. Being a single woman presents its own set of disincentives to disclosing a substance abuse problem (Donwood Institute, 1989). Besides the fact that, by being single, she has already stepped outside the traditional gender role for women, the fact that she is dependent upon a substance presents

added difficulties for her self-image. Often, a single woman's use of substances may be related to personal history (i.e., a history of physical or sexual abuse) and may be kept concealed for fear that her public image will suffer from disclosure.

> "In the modern American world, women live under different pressures. It should be obvious then, that the situations in which women become vulnerable to the disease of alcoholism are in large measures peculiar to women, and that they have special needs that must be met if they are to find their way back to normal, healthy living."
>
> -Margaret Mead, Anthropologist

Substance Abuse Patterns. Because of their patterns of substance use/abuse, women with addictions are likely to be less visible than men (Reed, 1987). Although trends are changing, especially for younger women, women are less likely to drink in public. This is attributable to the fact that women, drinking alone or in groups in a bar, are viewed differently than men.

Women also have an increased risk for abuse of addictive mood altering drugs and over-the-counter pain killers. These addictions are easily hidden given the ease with which pills may be taken and their use concealed. In addition, the use of "legal" drugs is viewed as having a legitimate medicinal purpose. Not only is the drug effective in making her feel better, but it is also validated as legitimate because it was prescribed by a physician.

The use of illicit drugs among women is greatest among women in their early twenties. Only among this age group is use of illegal substances by women on par with their male counterparts (Harrison and Belille, 1987).

Denial. Denial is a common coping mechanism for women and men with substance abuse problems. "No, I don't have a problem," is a common response by an addicted person to questions about his/her use patterns (Kinney and Leaton, 1987).

The pattern of denial presented by women is somewhat different than that presented by men (Reed, 1987). Men tend to blame their substance abuse on others or on the situation: a bad day at work, a bad marriage, an unreasonable boss are all common reasons given. Women, on the other hand, tend to internalize and blame themselves for their abuse of substances. They feel that it is the result of a personal flaw or shortcoming: "if only I were a better wife/ mother", "if only I could control my use like everyone else", "if only I had more will-power" are typical comments from women who are suffering with an addiction. This, in combination with increased stigma, reduces the tendency for women to acknowledge their addiction problem.

The mindset of a woman with an addiction is not unlike the learned helplessness commonly reported by battered women. In both cases, women feel powerless to make changes in their lives. They believe that they are responsible for their problems and there is little if anything they can do to change them.

Denial, as a barrier to identification, presents a paradoxical dynamic. The tendency for most professionals, when faced with a person with an addiction, is to want to force that person to face the reality of her/his substance use/abuse. However, this approach often results in further denial mixed with anxiety about the possibility that there may be some truth to the statement. Denial facilitates rejecting the suggestion that there is a problem; the resulting anxiety tends to trigger the use of the substance (Kinney and Leaton, 1987).

"We are not honest with our doctors anyway. They don't suspect you're an alcoholic, and we are not likely to confess to our problems."

-Woman in Recovery, St. John's

PHYSIOLOGICAL EFFECTS OF ALCOHOL ON WOMEN

The physiological effects of alcohol consumption on women is in some ways distinctly different from men. It can be much more debilitating to a woman. Some of these differences are:

Women Metabolize Alcohol Differently than Men

- Women's bodies have proportionately less muscle tissue than men. Since muscle tissue contains the body fluid that dilutes alcohol, women become more intoxicated than men on the same amount of alcohol, even when they weigh the same (Straussner, 1985).

- It takes longer for women to eliminate alcohol from their systems than men (Hill, 1984).

- Women who take birth control pills metabolize alcohol at a slower rate than women who don't. This increases the time it takes to eliminate alcohol from the body (Jones and Jones, 1976).

- Women have a more difficult time predicting the effect of the same amount of alcohol. They show greater day-to-day differences than men in their response to alcohol. In addition, monthly hormonal changes influence women's vulnerability to alcohol. Greater susceptibility to alcohol's influence occurs just before menstruation (Lundy, 1985).

Health Related Problems are "Telescoped" for Women

- Health related complications appear at an accelerated rate for women. This means that women's health problems related to alcohol can occur

after a shorter history of heavy drinking and with lower levels of alcohol intake than men (Curlee, 1970). For example, women run the risk of developing cancer or cirrhosis if they drink more than two drinks a day.

- Women are more susceptible than men to liver disorders as a result of alcohol consumption. Women have higher rates of cirrhosis and die of cirrhosis at a younger age than their male counterparts (Hill, 1984).

Reproductive and Gynaecological Effects

- In general, heavy drinkers have more gynaecological problems than light or moderate drinkers (Finkelstein et al, 1990).

- Women who drink heavily experience more infertility, miscarriages and stillbirths than women in the general population (Finkelstein et al, 1990).

- Women who drink when pregnant place their unborn child at risk for birth defects, for brain damage, and for general health problems (Hill, 1984)

Sexual Dysfunction

- Loss of interest in sex and sexual dysfunction are common among alcoholic women (Finkelstein et al, 1990).

- Sexual arousal is depressed by the toxic effects of high levels of alcohol; hormonal and adrenal levels are reduced producing loss of sexual arousal (Covington, 1984).

- Alcohol exerts psychological effects which may disrupt sexual functioning. Depression, low self-esteem, and tensions and conflicts in relationships all contribute to the disruption of sexual functioning (Covington, 1984).

Cancer

- Research indicates that the chance of developing breast cancer is related to alcohol use. Even low levels of alcohol consumption have been found to increase the chance of breast cancer (Finkelstein et al, 1990).

- Women who abuse alcohol are not only vulnerable to breast cancer and cancer of the liver, but also cancer of the lip, tongue, pharynx and esophagus (Finkelstein et al, 1990).

SYMPTOMS OF ALCOHOLISM

There are three stages of alcoholism: early, middle, and late. The symptoms and indicators of alcohol abuse are different in each of these stages. The most common signs for each stage of alcoholism are listed below. It should be noted that women move through these stages more quickly than do men. This has been referred to as the telescoping effect, indicating that women develop alcoholism later in their drinking life than men, and at a faster pace.

Early Stage

In the early stages of alcoholism, a woman is likely to sneak and gulp drinks. She may increase her tolerance to alcohol and may change the form of alcohol commonly used (e.g., beer to wine, wine to rum) so that her use can go unnoticed.

The early stage is also associated with visible changes in personality when drinking, a preoccupation with drinking, guilt feelings about drinking, and drinking to the point of drunkenness. A woman in the early stages may also begin to miss responsibilities of work and/or family, seek friends who drink, and lose interest in activities not directly associated with drinking.

Drinking may also influence interpersonal relationships at work and within the family. Tensions at work may increase, job changes may take place because of interpersonal problems, and tensions between spouses may be reported.

Middle Stage

In the middle stage of alcoholism a woman may begin to protect her supply of alcohol and may begin to drink during the morning or early afternoon. She may experience an increase in the incidence of infections and colds, and may have difficulties waking and getting out of bed in the morning.

During the middle stage, alcohol is more likely to be used to relieve anger or tension, or to deal with depression, fatigue, insomnia, or general social discomfort. A woman in the middle stage may take on a paranoid attitude about herself or about her drinking, is likely to have a stronger sense of denial about her problem, and may be found drinking more than she intended, even to the point of loss of control.

Attempts at abstinence are not uncommon during the middle stage. These attempts are generally unsuccessful. They may be followed by drinking despite knowledge that there are strong reasons not to drink. These reasons may be medical or health related, or they may be related to social factors (e.g., marital difficulties, family disruptions, inability to fulfill social responsibilities).

Late Stage

The late stage of alcoholism is easy to detect; it shows the most debilitating effects on health. During this stage, the woman with alcohol dependence syndrome will present with alcoholic hepatitis, cirrhosis of the liver, brain damage, alcoholic seizures, hallucinations, and delirium tremens (DT's). Tremors will often be visible even when sober.

Also in the late stage, there will be blatant and indiscriminate use of alcohol, a tendency to choose work or social situations which facilitate drinking, and a lowered tolerance to alcohol. Depression, social isolation, and suicide ideation may also be present. Related to hallucinations, there may be a fear of "going crazy", and there will be a visible lowering of personal standards for work and for dress.

PRESCRIPTION DRUG USE BY WOMEN

Substance abuse by both women and men is not limited to alcohol. The abuse of mood altering prescription drugs and some over-the-counter drugs are components of the addiction process which have special implications for women (Wilsnak and Beckman, 1984; Corrigon, 1980). This is in part related to the fact that women are prescribed, and use, mood altering drugs more than men.

The medical community shoulders some of the responsibility for patients' reliance on and use of prescription drugs (Cooperstock, 1977; Thompson, 1985). Medical education takes place in a society which not only condones the consumption of mood altering drugs, but promotes it. For example, advertising and health care promotion "markets" legal drugs as a way to deal with pain and as a means for enhancing overall well being. Alcohol, cigarette, and caffeine advertising frequently direct messages to women that reflect and shape their use of these drugs. "You've come a long way, baby," and "Four out of five doctors recommend...." are common examples.

These societal messages are further reinforced by modern medical education and practice. Until recently they have gone unchallenged. Drugs have been marketed to physicians using the biases and stereotypes of women as "sicker, and weaker" than men (Finkelstein et al, 1990). When drugs are seen as "medicine" and women are seen as "sick" it is both socially and medically acceptable for women to be prescribed powerful drugs as "treatment".

The passive role women hold in society coupled with the belief that "the doctor knows best" places women in double jeopardy. Women have been conditioned to expect and accept the medicalization of their health care (Thompson, 1985). The most common drugs they are prescribed include tranquillizers, sleeping pills, and barbiturates. Because of the complexity of symptoms associated with use of these substances, and the dearth of data about the toxic or negative

behaviour effects, it is difficult to describe common symptoms and effects of use.

Drugs Prescribed to Women[1]

Minor tranquillizers are the most commonly prescribed class of drugs in Canada. Valium, Librium, Serax, Equinil, Miltown and Xananx are examples of minor tranquillizers. They are prescribed by doctors to relieve anxiety or tension or as muscle relaxants; they produce calm without the drowsiness associated with the strong sedative-hypnotics. Minor tranquillizers have an extended half-life in the system and therefore can produce a painful and protracted withdrawal.

Barbiturates. Commonly prescribed barbiturates include Amytal, Butisol, Fiorinal, Luminal, Nembutal, Seconal. These depressant drugs, which are highly addictive, are prescribed primarily to treat insomnia and anxiety. When combined with alcohol, use of barbiturates can be life-threatening.

Sedative-Hypnotics (Nonbarbiturates). The frequently prescribed and highly addictive nonbarbiturate drugs include Quaalude, Dalmane, Doriden, and Noludar. These drugs are given to induce sleep, and produce a drowsy state. When given to women who are addicted to alcohol, sedative-hypnotics may create life-threatening situations from overdose as well as withdrawal.

Narcotics. Narcotic analgesics are highly addictive, pain killing drugs that may also produce a euphoric sense of well-being. Frequently prescribed narcotics are Codeine, Demerol, and Darvon. Some narcotics, such as

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[1] For additional information, see Finkelstein et al, Getting Sober, Getting Well: A Treatment Guide for Caregivers Who Work with Women, Cambridge, MA: The Women's Alcoholism Program of CASPAR, 1990.

Codeine, have valuable medical uses, but when used without medical supervision they are highly dangerous. Codeine is often combined with other drugs. A commonly prescribed drug in Newfoundland is Fiorinal with Codeine.

Antidepressants. Drugs frequently used for treating depression include Sinequan, Tofranil, Elavil, Norpramine, Pertofrane, and Aventyl. While they are not physically addictive, they do have side effects. When stopped abruptly, they may produce nausea and vomiting. They also have interactive effects with alcohol which increase the addictive effect of alcohol.

Amphetamines. Amphetamines, Benzedrine, Dexedrine, Preludin, and Ritalin, are stimulants which are prescribed as appetite suppressants primarily to women. These drugs produce a quick, temporary increase of energy when ingested. They also produce physical tolerance within a few weeks of use, requiring increasing dosages. They have a high potential for abuse and dependence. Chronic use can produce physical and psychological dependence, sleep disorders, and psychological disturbances.

Over-the-counter drugs. Women are also susceptible to the abuse of over-the-counter or non-prescription drugs. A wide variety are available for the self-medication of pain and discomfort. They include codeine-based cough medicines, sleeping pills, medications containing alcohol (e.g., cough syrups), diet pills and appetite suppressants which contain large amounts of caffeine.

Effects of Mood Altering Drugs on Women

Many minor tranquillizers have a similar pharmacology to alcohol; they have similar effects. They are therefore often used along with and as a substitute for alcohol.

While a woman may abstain from alcohol, she may use powerful prescription drugs in its place. This has a number of serious consequences. *Cross addiction* and *cross tolerance* are two possible side effects of combining alcohol with some mood altering drugs. Cross addiction refers to the dependency on alcohol **and** another drug with similar pharmacology. Cross tolerance means there is an increasing need for either or both substances in order to maintain the same effect.

In addition, combining alcohol with certain mood altering drugs such as tranquillizers and barbiturates creates an addictive (synergistic) effect. This additive action means that tne combination of both drugs is greater than the individual effects of each drug on its own. The addiction is increased and withdrawal effects are also increased. The possibility of accidental overdose is also increased. The use of prescription drugs by alcoholic women can become a life-threatening condition because of intentional and unintentional drug overdoses while drinking.

ILLICIT DRUG USE BY WOMEN

Women have historically been more likely than men to use socially acceptable, prescription drugs and to perceive the use of these "legal" drugs as a form of coping (Reed, 1985). These prescription drugs may also be obtained "on the street" without a prescription. Women's use of these Black Market Drugs, and use and abuse of "illegal" drugs cannot be ignored.

In a recent study of women with addictions surveyed in St. John's, Newfoundland (Woodland, 1989), over half (56%) of the women reported some combination of substance abuse. Alcohol and prescription drug addiction was the most common (46%) cross-addiction reported, followed by the combination of illegal drugs and alcohol (27%). A poly-addiction between alcohol,

prescription drugs and illegal drugs was reported by 21% of those participating in the study.

Even though a woman may be using more than one illegal or legal drug, one drug of choice will usually predominate at any given time. The abuse of multiple drugs, including illegal substances especially by younger women, is a current trend emerging both in clinical settings and the research literature (Harrison and Bellille, 1987).

Illicit Drugs Most Prevalent Among Women[1]

Marijuana and Hashish. The Canada Health Promotion Survey (1988) reports that the prevalence of use of these drugs is highest among younger age groups. The study reported that more men than women used these drugs except among those in the 15-24 age category where parity of use between the sexes was reported. In low to moderate doses pleasant feelings of relaxation and well-being are experienced. Some of the symptoms of chronic abuse include mental confusion, inability to concentrate, poor attention span, difficulties with attention and concept formation, and with extended use paranoia and self-destructive behaviour.

Cocaine. Cocaine is a stimulant drug in the same classification as amphetamines. The Canada Health Survey (1986) reported that while men are twice as likely to use cocaine as women, both male and female users are most frequently reported in the 15-24 age category. Common symptoms for women who abuse cocaine include insomnia, depression, paranoia, agitation and irritability. Women who use cocaine when pregnant increase their risk for spontaneous abortions, stillborns and fetal death.

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[1] For additional information, see Finkelstein et al, Getting Sober, Getting Well: A Treatment Guide for Caregivers Who Work with Women, Cambridge, MA: The Women's Alcoholism Program of CASPAR, 1990.

Hallucinogens/Psychedelics. These include LSD, mescaline and psilocybin. Although the popularity of these drugs has decreased in the last decade, their use may accompany the abuse of other illicit substances. Heavy use of these drugs may result in mental and emotional problems persisting well into sobriety.

Methamphetamine. Often referred to as crystal, methamphetamine is a potent form of speed. It may prompt the simultaneous use of tranquillizers and barbiturates to deal with resulting depression. Addiction to crystal can lead to extreme weight loss, personality changes and psychosis. Anxiety, intellectual confusion and extended insomnia are common withdrawal symptoms.

"Black Market" Drugs. Prescription drugs, such as minor tranquillizers, barbiturates, anti depressants, amphetamines and narcotic analgesics are sometimes acquired on a "black market". The extent of the problem is difficult to document. Statistics from the United States indicate that current prevalence rates for women are more than double that of men (Finkelstein 1990).

ISSUES AROUND CO-DEPENDENCY

Understanding co-dependence is important for two reasons. First, it is important to be alert to the impacts on the family system of a family member's addiction. The first signs of a substance abuse problem may be visible through the family members and family dynamics. While a woman may not disclose a substance abuse problem, she may disclose the family problems that are associated with substance abuse and co-dependence.

Second, women often become co-dependents in their spouse's addiction. Signs of co-dependence should be sufficient to ask for additional information

and/or to provide intervention or referral. It is interesting to note that while only 10% of males stay with a spouse who suffers an addiction, 90% of females remain with a spouse who is addicted (Fraser, 1974).

When there is an addiction problem, everyone is affected. Family members and friends may at one and the same time be adversely affected by the addiction and drawn into behaviour patterns which support the addiction. This impact/support has been characterized as "co-dependency". The co-dependent spouse, child, or friend is seen as having developed a pattern of coping with life that is not healthy. Co-dependency is separate from but in many ways similar to an addiction. It is of interest here in that women often become co-dependent.

Some characteristics of co-dependency are: caretaking, low self-worth, denial, dependency, lack of trust, difficulty identifying feelings, difficulty expressing feelings, perfectionism, rigidity and need for control, constant need for approval from others, insecurity, low self-esteem, feelings of powerlessness, difficulty making decisions, victimization and martyrdom.

Co-dependents take on what is often referred to as "enabling" behaviour. This is destructive to the addicted person and to the co-dependent. Enabling behaviours include denial, minimizing problems, protecting, fixing, rescuing, blaming, nagging and avoiding conflict through "peace keeping".

QUESTIONS FREQUENTLY ASKED BY PROFESSIONALS ABOUT IDENTIFYING WOMEN WITH ADDICTIONS

Why is it that I never see a woman who identifies an addiction?

- A woman who comes to your service will not readily identify her addiction to alcohol or drugs. Instead, she will come presenting a problem that is more socially acceptable to treat. Commonly she may present herself with feelings of depression, anxiety, "bad nerves", insomnia, or migraine headaches (Woodland, 1989; Mulford, 1977).

- A woman may not realize that she is addicted because she is protected by her family and friends. Despite the fact that her substance use is having an impact on her family or on fulfilling her responsibilities, those around her may help out so that those things needing to be done are taken care of. In the interest of "allowing things to work out" or "helping her through a difficult time", family and friends may enable the woman to continue her use and abuse of a substance.

- A woman may feel that she has legitimate reasons for her chemical use. It is common for the woman to say that since all of her friends drink or use drugs it should not be viewed as a big deal. In addition, since many women's addictions are to prescription drugs, they can readily say that they are only following the instructions of their physician.

What is the profile of the typical woman with an addiction who presents for help?

- There is no typical woman with an alcohol or drug use problem. Addiction is not assigned to one type of woman. Single, married, separated and divorced women are all vulnerable. Women of all ages, social positions,

and economic backgrounds are affected. A woman with an addiction has an equal likelihood to be a doctor, lawyer, or other professional, a homemaker, a business executive or middle manager, a skilled or semi-skilled worker, or an unskilled worker. Women who drink alone and women who drink socially are all at risk to present with a problem.

There are some risk factors that are worth while to note:

- A family history of alcohol or drug addiction
- Living with a spouse who has an addiction
- The absence of social support systems when help is needed
- Use of alcohol/drugs to cope with everyday problems
- Having friends who use alcohol/drugs "socially"
- Low self-esteem

RECOGNIZING WOMEN WITH ADDICTIONS

MYTH OR TRUTH?

- There are no addicted women in small communities. If there were, we would see them and know about them.
- If a woman really cared about her family and her children she would quit her use of alcohol or drugs.
- Professional women are less likely to be addicted to substances than other women.
- The effects of alcohol are precisely the same for women and men.
- The patterns of substance use, and the reasons given for use, are the same for women and men.
- "An alcoholic is an alcoholic"; all alcoholics are fundamentally the same.
- You have to reach your rock bottom before you can get help.
- Women and men respond the same to the same methods and modalities of treatment.
- Professionals are just as likely to ask their female clients/patients about their use of substances as they are to ask their male clients/patients.
- The stigma surrounding alcoholism and other substance abuse is the same for women and men.
- The typical female alcoholic is the "hidden" housewife or a closet drinker.
- Fewer women than men seek treatment for substance abuse simply because there **are** fewer addicted women.
- Professionals, including doctors, routinely question their clients/patients about their consumption of alcohol and other drugs.

MYTH OR FACT??? Each of these statements is a commonly held myth. The "fact" of each of these statements is discussed in the text of this chapter.

REACHING OUT TO
WOMEN WITH ADDICTIONS

If you are like most professionals, it is unlikely that an alcoholic or drug using woman has walked in the door of your office and declared herself an alcoholic or addict. Even on the occasion that you have suspected an addiction, it is unlikely that you have confronted many women about this. It may surprise you, but you are not alone.

Most help-giving professionals do not know a lot about alcoholism in general, or about women and alcohol in particular. Very few have received comprehensive training in addictions as part of their professional education and development. Therefore, very few recognize alcoholism or other addictions as part of the problems that they are dealing with. There are many reasons for avoiding this with clients.

It is important not only to increase our knowledge about substance abuse and women, but also to examine our own attitudes, biases and expectations about addicted women. This is important if professionals are to evaluate their responsibility as professionals and to develop a strategy for their role in identifying and reaching out to women who suffer with an addiction.

This chapter will present strategies for reaching out to women who are perceived as presenting with a substance abuse problem. It will address:

- why asking about substance abuse problems is avoided,
- when substance abuse problems should be asked about, and
- how one may go about asking about a client's/patient's patterns of substance use.

It will also discuss methods that may be used for motivating a woman to seek specialized treatment for a substance abuse problem.

WHY WE AVOID ASKING

There are a number of reasons why we tend not to ask about substance use and abuse when a client or patient visits us. The most obvious reason is that we don't think to ask. However, there are some other reasons (see Finkelstein et al, 1990). They include:

Because of our lack of knowledge we may:

- have difficulty in identifying, recognizing, and diagnosing substance abuse, especially in its early stages.

- treat the secondary effects of alcoholism and other drug abuse, rather than the abuse itself. For example, we may treat psycho-social problems such as depression, paranoia, or suicide ideation, each of which may be secondary effects of the alcoholism. Or, we may treat the physiological effects of substance use (e.g., gastrointestinal ailments, sinusitis, sluggishness) without identifying the abuse itself.

- believe that if we help our client change or solve her identified problem, she will stop needing to consume alcohol or drugs. For example, rather than treat the chemical abuse, we may support a change in job, support a decision to leave a relationship perceived as unsatisfactory, or provide support for a change in her living situation.

Because of our lack of skills we may:

- want to ask about drinking or substance abuse, but just don't know how.

- be intimidated by the possibility of being wrong. We may fear that our client will be insulted and angry if we suggest that she has a substance abuse problem, and that our professional judgement will be questioned. We may fear loss of our client, patient or friend because of this.

- be afraid of the possibility of being right. She may not be ready to deal with her substance abuse problems, and now that I know she will go to someone else. We feel that we can help her because we know her history - - "at least I know how many pills she takes or how much she drinks."

Because of our personal attitudes about substance use/abuse we may:

- think that addiction is a moral issue and a reflection on the moral character of our client. If we bring this up we are saying that she is not a good person.

- feel that she has so many problems to deal with in her life that her "bottle" or "pills" are her only comfort or her only means for numbing the pain. We question how we can take that away from her.

- believe that an alcoholic cannot be helped unless she hits "rock bottom" and asks for help, so why bother until she reaches that point.

Because of our own personal issues we may:

- believe that if she wanted help she would ask for it. We feel that it is neither our role nor our right to question her about how she lives her life.

- believe that substance or alcohol use is acceptable and something which, because we can control its use, others must also be able to control.

- have unresolved personal experiences around substance use. We may be concerned about our own drinking or substance use, or about someone close to us who is struggling with the abuse of substances. Consequently, we may find it difficult to confront the issue without dealing with our own feelings.

WHY ASK? THE ROLE OF THE CAREGIVER

There are a number of reasons why it is important to ask those who you believe have a substance abuse problem about their chemical use. The most important reason is that alcoholism is a progressive condition that is fatal if untreated. Addiction to drugs is no less debilitating and no less serious. Therefore, it is essential to understand how asking can help, and its role in initiating the treatment process.

Denial As a Response. As discussed above, denial and resistance are two components of the dynamic characterizing an addiction. Each of these is supported when a client is not asked about her addiction. Asking questions about patterns of drinking or drug use gives the client the opportunity to admit (or to refute) her substance abusing behaviour. When a professional avoids the issue the client is able to avoid the decision to get help. This is a loss of the first and important step for an addicted woman.

It should be noted that asking about chemical use should be handled with sensitivity and with care. Questions should be asked within a context of support and acceptance. If caregivers are sincere in their expression of support and acceptance, information may be shared. However, cautiousness should be used so as not to rush the client/patient to divulge too much at one time. She should be allowed to express what she is willing to share freely, but should not be pushed for more than is offered!!

Also, be prepared. You may get more information than you bargained for. If you find yourself in a situation where you aren't sure how to proceed, ask for help. Don't hesitate to call the Alcohol and Drug Dependency Commission, or an addictions counsellor, for assistance.

Dealing with the Crisis. An addiction is a crisis in a client's life. A professional is likely to recognize the importance of dealing directly with other crises in a client's life. For example, a professional is likely to deal directly with a potential suicide or bereavement, either themselves or through referral.

The need to deal directly with an alcohol or drug addiction is the first and most important step in recognizing that the problem exists and must be dealt with. A woman can only start recovery after acknowledging and accepting that she has a problem. Once she believes that she has a problem, she can begin to face up to the consequences of her substance abuse.

If a substance abuse problem is not dealt with directly, the use will be allowed to continue and the person's life situation will likely continue to deteriorate. While not asking is easier, the fact remains that avoiding the question wastes valuable time for you and your client. If you are providing counselling services, it is unlikely that therapeutic gains will be made if the underlying problem of addiction is ignored or avoided. If you are providing health services, treatment may only be marginally effective if the real problem remains unaddressed.

To Ask Brings Hope. Asking about her substance use can bring with it a sense of hope on the part of the woman with an addiction. Avoiding the questions about her chemical intake reinforces her feelings of hopelessness and loss of control; it gives a message that she is beyond help. Asking, on the other hand, makes the problem visible and allows the woman to see that there are things she can do to improve her situation. She may have a renewed hope about her future and see ways in which she can regain some control over her life.

Are There Risks in Asking? The largest risk of asking about chemical use is that you may lose the client or patient. She may seek help from someone else who is not going to confront her with her problem. You have to be prepared for

this rejection. There is some consolation in knowing that her seeking another's help indicates that your message has been heard.

WHEN SHOULD I ASK A WOMAN ABOUT HER SUBSTANCE ABUSE?

It is appropriate to ask a woman about her drinking and use of drugs when you first suspect that her use is a problem. It is not necessary to have a definitive diagnosis of alcoholism or of an addiction before asking. If there is suspicion that a problem exists, then you should ask. Asking questions relating to behaviour and/or life problems that may be caused by her drinking and/or drug use is one way in which the topic may be raised.

It is not appropriate to question a woman about her use patterns or problems related to chemicals when she is intoxicated. There may be an inclination to ask her when you have "proof" to back you up; however, little will be gained by proceeding during this time. She is likely to be more defensive, and may not be receptive to discuss the issues you want to raise. Even if she discusses her use of alcohol with you, she may not subsequently remember the conversation. It is best to wait until both you and your patient/client can talk openly and freely, free of anger, frustration, or resentment.

Questions about drinking and drug use need to be asked within a climate of trust, caring, and compassion between caregiver and client. Even initial screening questions that are part of an intake interview and assessment, and that may be somewhat superficial, should be asked in a sensitive and supportive way. It may take time to build a relationship where drinking and using behaviours can be dealt with openly and honestly. However, one should not fall into the trap of putting off questioning, waiting for the "best" time. There is no best time!

HOW DO I ASK QUESTIONS ABOUT DRINKING AND SUBSTANCE USE?

It commonly feels awkward asking a client/patient about her patterns of alcohol or drug use. However, by asking we increase our comfort with the questions and gain a better sense of how to handle the answers. We also learn how to focus and ask questions that will give us the information that we need.

Questions that may be asked of a woman who you believe has a substance abuse problem follow. Issues that should be considered in asking questions about substance use are also raised. A primary rule for any question is that it be clear, concise, and unambiguous. This information is not intended to be complete or comprehensive. The Appendix includes reference materials that may be used for additional information.

Some Questions to Ask About Substance Use

- How often do you drink beer, wine, or liquor?
- In what situations do you commonly drink alcoholic beverages?
- How much beer, wine, or liquor do you drink in a usual day?
- What prescription drugs do you use? How often do you take these drugs?
- Do you use any other drugs? How often do you use these drugs?
- Have you ever had concerns about your use of alcohol or drugs?
- Do any of your friends have problems with alcohol or drug use?
- Does anyone in your family have alcoholism or problems with alcohol or drug use?

If you want to continue to explore substance use further, you may want to ask some of the following questions:

- Have you ever tried cutting down? How? What was that like for you?
- Do others ever criticize your drinking? Does this annoy you?
- Do you feel there are situations or times that you need a drink or need to take a drug?

- Do you ever feel guilty about your drinking or drug use?
- Do you ever have blackouts (i.e., periods that you cannot remember)?
- Do you ever get physically sick from drinking or from drug use?
- Have you ever had regrets about something you did while intoxicated?
- Are there any problems you find that are caused by your drinking or drug use?
- If you stopped drinking or using drugs, how would your life change? In positive ways? In negative ways?

There are some considerations you should keep in mind when asking questions about the use of alcohol or drugs. These include:

1. Do not use labels such as alcoholism, addict, druggie. Asking about "a problem with alcohol or drugs" is more acceptable and less judgemental. It has less stigma attached to it.

2. Strive for a nonjudgemental attitude. This includes using appropriate verbal and non-verbal cues. Your tone of voice, gestures, and facial expressions can be extremely important.

3. Ask direct questions that call for factual answers. Do not discuss rationalizations. To be drawn into such a discussion may divert the interview and avoid the real issues.

4. Be sensitive to any reply in which a client insists there is no problem. There may indeed be one!

5. Focus on the use of open ended questions. This will allow the client to talk more freely and provide additional information on which you can make your judgements.

IF I HAVE DETERMINED THAT THERE IS A PROBLEM, HOW DO I MOTIVATE A WOMAN TO SEEK TREATMENT FOR HER PROBLEM?

There are several things you can do that will help motivate and increase the likelihood of a woman seeking a specialist's help for her substance use problem. You may attempt to:

1. Help educate her about alcoholism as an illness; help her accept the diagnosis and see the hopefulness of recovery.

2. Help her make connections between her problems and her use of alcohol or drugs. This is important because you have probably been seeing her for problems **other** than alcohol, although alcohol or other substance abuse has been an underlying problem.

3. Provide her with information about resources. You will find information in the next chapter and in the Appendix of this guide that will prove useful in this regard. It includes resources for referral and treatment of alcohol and substance use problems. It also includes suggestions for further reading.

4. Provide support for her to get treatment. For example, you may offer to accompany her, or arrange for another to accompany her to a support group meeting (e.g., A.A., N.A.). If necessary, help her deal with child care arrangements or other barriers to her attendance.

5. Set very clear limits. Let her know how and when her substance use is interfering with your work together. Do not see her when she is intoxicated; make clear contracts around her substance use.

6. Help her set short-range goals: adopt the "one day at a time" philosophy. Reinforce small successes like going to a support group

meeting, trying to remain substance-free for an hour, a day, a week or a month, or cutting down in the level of substance use. Small successes may provide the basis for bigger successes in the future.

FREQUENTLY ASKED QUESTIONS ABOUT REACHING WOMEN WITH ADDICTIONS

"What do I do if I identify a woman with an addiction and there are no services or treatment available in my area? Isn't it better to leave well enough alone?"

- You may feel that way initially, but this is probably not the first time this individual's problem has been noticed by a professional. To be left without comment, and without treatment, only means that the problem will get worse.

- The lack of specialized services is a fact of life in rural parts of Newfoundland. The fact is that as a professional you are faced with other problems for which specialized services are not available in your area. You more than likely deal with these problems by making referrals to a specialist. Referrals should also be made for addictions.

- If the addiction is to a prescription/mood altering drug, withdrawal may be managed by a physician. Most areas, even the most remote communities, have access to a physician.

- Remember, alcoholism is a progressive, fatal condition if left untreated. There are very few women with an addiction who, once they are in recovery, blame professionals for dealing directly with their addiction issues. However, there are many who blame professionals for not asking about, identifying, and dealing with their addiction.

"What if my asking about an addiction precipitates a crisis for the woman? I don't want to be responsible for her doing something drastic."

- If a crisis does occur, it was there before you asked your questions. The important thing is to be prepared to help your client start dealing with and accepting the problem. It may not be easy, and if you find that you are in "over your head", ask for help. Contact the Alcohol and Drug Dependency Commission or other specialist.

"How do I deal with a woman who doesn't want help, but who I firmly believe needs it? Do I keep confronting her or do I leave her alone?"

- Denial is part of all addictions. It is reinforced in women because of the double stigma they feel. They are stigmatized as a woman, and are

stigmatized again because of their addiction. Be aware that there are many social forces that reinforce her denial.

- Working out a strategy and line of questions for dealing with these types of situations will prepare you for approaching them effectively. Know the prerequisites: build an atmosphere of trust and acceptance.

- You need to accept the fact that your client may not be ready to deal with the addiction and that confrontation may cause her to leave the relationship. This is not a negative reflection on you, or on the fact that you raised the issue. It may take several approaches before you are able to get past the well developed system of denial and avoidance.

"Well, how exactly do I approach her? Is there some formula I should follow?"

- There is no formula. You should approach her when you first identify a problem. Putting it off makes it more difficult for you and adds other dynamics to the relationship between you and your client/patient. It may send a message that "she is beyond help" or that you don't see that there is a problem or concern. She can take from this a message that everything must still be in control and ok.

- Be specific and concrete in discussing your perceptions. Point out **specific observations** that you have noticed; don't make general comments that can be misinterpreted.

- Be non-judgemental and listen well. Basic counselling skills emphasize the importance of active listening. For example, reflecting back what the client is saying (e.g., "What I hear you saying is that .....") is one technique to let her know you are listening and to ensure that the message you received is the one she meant to send.

"What about women who have been physically and/or sexually abused and are also addicted? Are there many women who fall into this category? How do I deal with all these issues?

- Estimates are that up to 70% of the women with addictions who present for treatment have experienced physical or sexual abuse. Studies also indicate that between 50-70% of women who have been physically or sexually abused will develop an addiction. For women, there is a very strong connection between addictions and having experienced abuse

(Wilsnak, 1984). It is therefore important that such disclosures be given credibility and be treated confidentially.

- Generally, if there is an addiction, there is a likelihood that there are a variety of problems in the woman's life. These need to be brought into the open, acknowledged and accepted, if they are to be dealt with. Since they are best dealt with in a holistic and practical manner, it is often best to refer her to a person who can provide services for the range of presenting problems.

- There are some resources that are available and may help.

  I Am Worth the Effort: A Handbook for Women in Abusive Relationships is an excellent reference for resources. It is available through the Iris Kirby House, P.O. Box 6208, St. John's, A1C 6J9.

  Understanding Wife Abuse: An Educational Manual for Community Groups in Newfoundland and Labrador is useful for gaining a better knowledge about the problem of wife abuse in the province. It is available through the Women's Policy Office, Confederation Building, P.O. Box 8700, St. John's, A1B 4J6.

REFERRING

WOMEN WITH ADDICTIONS

This section of the manual presents information that may be useful in referring women you suspect or have identified as having a substance abuse problem or an addiction. This section will first provide an overview of the treatment options available to women. It will then provide suggestions of where referrals can be made, and how you may go about making a referral. If you wish additional information about resources or about who to contact for more information, consult the Appendix of this manual.

TREATMENT

The treatment of women with addictions needs to be considered in terms of three separate issues.

- the settings that may be used for treatment
- the methods that may be used for treatment
- needs, specific to women, that must be considered in choosing treatment programs

Treatment Settings

Treatment services for women with addictions (alcohol and drugs) are provided in a variety of settings. Most treatment programs require detoxification as a first step before admission.

Detoxification is the process of withdrawing completely from drugs and/or alcohol. It is viewed as a necessary step in all treatment programs. The time needed for detoxification varies. The alcohol addicted person may need from three to seven days; persons with drug addictions may need as long as six weeks, although they may detoxify in as short a time as two or three weeks.

It is estimated that between 80 and 90 percent of all detoxification occurs in the home setting without the support of professional services. While detoxification at home is most effective for those who have a stable residence and a family member or other person who is willing and able to provide support and protection, women are less likely to have the support systems needed. Unfortunately, it is very easy for those who attempt detoxification at home to fall through the cracks. They are less likely to be identified as needing medical care, and less likely to be referred to a community agency for further rehabilitative treatment and follow-up.

Traditionally, detoxification services have been placed in hospital-based settings and have followed a medical model. More recently, some detoxification and treatment services have moved outside of hospitals and have adopted a non-medical model. Many of these programs still include medical personnel but have a strong emphasis on providing services in a social setting and remaining more community-based. Detoxification services in Newfoundland are listed in the Appendix of this manual.

Hospital Settings - Inpatient. The traditional hospital-based program is inpatient. Individuals remain in hospital for the period of time needed to detoxify. After detoxification, they may either remain on an inpatient or shift to an outpatient basis during treatment. Typically within hospital settings, patients are confined to a separate ward and drugs may be prescribed during withdrawal. These may include chlorodiazepoxide (Librium), diazepam (Valium), and phenobarbital.

Detoxification and treatment within a hospital setting is viewed as most appropriate for patients who present with physical and/or psychiatric problems that are potentially threatening, those with a recent history of a serious medical problem, and those who are physically dependent on a psychoactive drug.

Hospital Settings - Outpatient. It is widely believed that the majority of patients who seek help can detoxify and receive treatment as outpatients. This is an approach that is particularly appropriate for women. Patient visits are on a daily basis or less frequent, depending on the circumstances. Medications (tranquillizers and anti-convulsants) may be used in outpatient treatment services.

Hospital Settings - Daypatient. A sub-group of outpatient services is the "day hospital". This approach was started in the United States in response to the need for an acceptable approach for the "middle class" alcoholic/drug user who was unlikely to accept treatment within a residential program. While similar to the outpatient model, these services are often not available on a 24 hour a day, 7 day a week basis. Day hospital is a specific program offered during the day (Monday through Friday).

Non-Hospital Settings. Detoxification and treatment services within a non-hospital setting are generally ambulatory rather than bed-based. The services are often provided in a program that is residential in nature and which has a referral link to a medical facility.

Non-hospital programs apply the philosophy that the majority of patients do not require medical care and that the administration of mood altering drugs is not necessary. While hospital-based programs are administered by doctors and nurses, non-hospital programs rely on medical professionals as consultants for medical assessment and referral when appropriate. Services are provided by persons trained specifically in addictions services. Staff may include social workers and psychologists, and often also include individuals who are in recovery themselves and whose credentials are training programs rather than university degrees.

The non-hospital setting is most appropriate for individuals not needing medical intervention, but requiring a residential program that provides social support and both individual and group counselling. It is particularly appropriate for individuals who have proven unable to detoxify and continue treatment on an outpatient basis.

Treatment Approaches

There are a variety of treatment approaches and methods for addictions. Those that are commonly used include individual counselling, group work/support groups, family treatment, Alcoholics Anonymous, relaxation therapy/meditation, behavioural therapy, and the use of disulfiram (antabuse). A brief description of each of these methods is provided below.

Individual counselling. Counselling is an art, not a technical skill. Given the specialized nature of counselling persons with addictions, it is impractical to suggest instructions for how to counsel a person with an addiction. However, some insight may be provided by discussing how the counselling process typically begins.

In an initial interview, the counsellor will often provide the client an opportunity to discuss the problem she has, as she sees it. She will be asked what she wants, and what brings her to asking for or wanting help now. Through the interview, the counsellor will determine what is currently going on in the person's life (i.e., with family, with friends, with work, social problems, medical problems, and substance use patterns), and will work with the client in formulating a plan for where future sessions should take them.

Counselling a person with an addiction is, in many ways, more difficult than other types of counselling. While it may be tempting to "try your hand" at it, it is important to refer a person with an addiction to a specialist. Simply, persons

with addictions tend to be manipulative and sophisticated at hiding the reality of their situation. They can effectively make you feel that you are having a positive impact and that you are changing them for the better, just to get you "off their backs."

Alcohol counsellors can relate many stories. Some common statements heard include:

> "Gee, you've really helped me see exactly what I have to do. I'll do x, y, and z, and everything will be just fine. Thanks so much for your help."

> "Well, both of my parents were alcoholics. I even had a grandparent who was an alcoholic. But, you know, I don't drink the way they did. It really only started when my son started acting out at school. And then my husband started working overtime. But the overtime is due to end next week, and I am sure that now, with all the information and help you have given me, I will be able to stop on my own and everything will be fine. Thanks so much for your help. You have changed my life."

Most people with an addiction are quite inventive. Not only can they say the right things, but they can also very quickly draw you into a role supporting their addiction. Suffice it to say that counselling is one effective approach for treatment of persons with addictions. This counselling, however, should be provided by a trained addictions counsellor.

Group work/support groups. The use of groups as a method for treatment of persons with addictions is a part of most treatment programs, and is generally quite effective. The value of a group is that it brings together persons with similar experiences and similar struggles. They quickly find that they are not the only ones struggling with the problem of alcohol abuse or drug abuse; that their experience, their thoughts, their feelings are similar to others who have the same problem.

The group provides a form of social support for the alcoholic or drug-addicted person. It also provides a setting in which participants can talk freely about their problems without fear of negative judgement because of an inability to control their use or because of the things they have done while intoxicated. Participants are with others who know exactly how they feel and what they have been through.

Through the use of a group as a therapeutic method, individuals are able to gain a perspective on their lives and their situations. They are also able to use the group to help think through what can be done to make things different. They can draw on each other's experiences and each other's insights. Since participants know all of the "tricks" and all of the excuses frequently used by persons with addictions, the group can effectively confront individuals with their self-deceptions and work to help them be honest with themselves.

Family treatment. Members of a family where an addiction problem exists often need treatment as much as the person with the addiction. Frequently, it is the family that has finally pushed the person into treatment. Resentment toward the person with the addiction may have developed, interpersonal tensions may exist, and conflicts may remain unresolved. Family treatment would work to identify these problems and would deal with them directly. It could help strengthen the marital bond and re-establish healthy connections between parent and children.

Treatment of the family is also important if co-dependent relationships are to be dealt with. Often, the family supports the individual's substance use and addiction. They enable the addiction and problems associated with it to continue by covering up for unfulfilled responsibilities and for inappropriate behaviour. The family must learn to deal with the addiction problem, to provide support for recovery, and to confront old patterns that re-emerge.

Self-Help Groups - Alcoholics Anonymous. AA stresses abstinence and contends that nothing can really change for addicted persons until they stop drinking or using a substance. This view is shared by most addictions counsellors. The view is that a drugged person cannot comprehend or make effective use of treatment. As long as the drug (and alcohol is a drug) is present, treatment cannot be successful. As AA states, "it is the first drink that is the problem, not the last one."

Each person involved with AA has his/her own personal goals. For some, merely making it through the day or through the week without a drink is the sum total of their purpose in being associated with AA. For others, AA may provide the means by which they can establish and support a new way of life. Goals vary from person to person and may change across time as a result of involvement with AA.

Relaxation therapy/Meditation. A strategy employed by some treatment programs is to include training for relaxation or for meditation. Relaxation therapy is based on the assumption that if the mind and body are relaxed, it is impossible to feel anxious or stressed. Techniques are used which help individuals become aware of their breathing and to be aware of tension in various parts of their body. They are instructed in methods to overcome feelings of stress and anxiety and to deal with these feelings in a constructive and healthful way.

Meditation has slightly different methods, but its goal is to reach a similar state of relaxation. The patient usually achieves a state of relative relaxation first, and then allows the mind to wander. The patient may daydream, or think about the meaning of her life, or search inwards into her motives, values, and wishes. The direction taken through meditation is determined by the person. It is often an effective method for gaining self-awareness and resolution for future direction.

Behavioural therapy. Most of us are familiar with behaviour modification and the use of behavioural therapy. The approach is based on the assumption that the behaviour is learned through a series of positive inducements (rewards) and negative sanctions (punishments). Therapists who use behavioural therapy provide rewards for those behaviours that they wish to engender in a person and punishment for those behaviours they wish to extinguish.

Early applications of behavioural therapy employed the use of aversion therapy in which people were given electric shocks when they swallowed an alcoholic beverage, or were given a drug similar to disulfiram which would induce sickness when the person took a drink. These forms of aversion therapy have become less popular in recent years. More commonly, behavioural therapists utilize one of the following two approaches:

Systematic desensitization, which is often used with persons who consume drugs during times of stress or anxiety. Through the use of relaxation techniques individuals are taught to desensitize themselves to the stress and anxiety they feel, which in turn makes the need to consume a mood altering drug unnecessary.

Positive reinforcement techniques, which utilize a reward system to give positive support to desired behaviour. Rewards are identified that are important to the person being treated. For example, if a woman does not drink or use drugs, she may be rewarded with going out for dinner, going to a movie, having a day off from child care, or having a day to herself. Goals are often short-term, simple, and realistic in nature.

Disulfiram (Antabuse). A group of Danish scientists discovered disulfiram in the 1940's. They found that the drug produced a significant reaction when alcohol was ingested by a person who had taken it. Possible reactions include throbbing in the head and neck, difficulty with breathing, nausea, sweating,

rapid heartbeat, and weakness. The intensity of the reaction varies from person to person, and varies with the amount of disulfiram present in the body and with the amount of alcohol ingested. Since disulfiram is excreted from the body quite slowly, the possibility of a reaction to the ingestion of alcohol may be present for as long as four or five days.

Women's Treatment Needs

There is literature that supports the argument that the treatment needs for women are different than the needs of men (Reed, 1985). This literature indicates that the types of treatment that are most effective with women are different (Beckman and Amoro, 1985). In addition, women have needs that must be dealt with before they can effectively enter treatment. This section addresses women's treatment needs and the question of whether women should participate in the same programs as men, or whether they need programs that are structured differently.

What are some of the special needs women bring to treatment?

Women have a number of needs that must be dealt with in treatment. In addition to individual, family, and group therapy, it is important for a program serving women to be prepared to deal with issues of low self-esteem, extreme stigmatization, the probability of sexual abuse, and lack of social supports. In addition, many women must have access to child care services if they are to participate in any treatment services (Woodland, 1989).

What factors are relevant for motivating women to treatment?

We know that women bring special needs to the treatment process. Their experiences as women differ from those of their male counterparts. In many cases, their experiences as women cannot be separated from their experiences as addicted persons (Zamkowski, 1987). A treatment program that motivates women is one that removes many of the disincentives to their

participation. This may mean providing women-only groups and providing child care services. In addition, the program should provide:

- family counselling
- professional treatment staff sensitive to women's needs
- aftercare programs such as life skills training, employment training, parenting training, self-esteem building
- women's support groups
- counselling for battered women
- counselling for incest victims
- medical and nutritional counselling (especially for pregnant women)
- treatment for mood altering drugs and for polyaddictions

Do women and men need different treatment strategies?

A number of experts have emphasized the need for different approaches to the treatment of male and female alcoholics. Experience in clinical settings shows the importance of an all-women approach for at least part of the recovery process. It has been shown, for example, that women are more passive and take on a nurturing role in groups which include both men and women. In all-women groups there is more sharing between members and a greater sense of empathy and support. This is particularly true given the fact that many women in recovery are also dealing with a history of physical and/or sexual abuse (Underhill, 1986).

Can existing treatment programs be adapted to be more responsive to women and the needs they bring to the treatment process?

Yes. Experience with many programs indicates that there are a variety of initiatives that can be introduced to meet the needs of women. These include the introduction of:

- specialty seminars for women designed to promote adequate coping skills. These would be distinct from the mixed, general addiction education seminars. Seminars would include information pertinent to women with regard to effective (sober) parenting, managing role conflict, sexuality and birth control, family communication, assertiveness training, planning leisure time, and vocational training.

- providing services which do not have grossly unequal sex ratios in group sessions and which are available during times that are convenient for women - day time sessions, for example. Weekend, evening, and full-time attendance may not be practical for women clients, particularly those with family or child care responsibilities.

- training that raises awareness of staff to women's issues and concerns. It is important to educate all staff on the social forces that affect women's lives and how these impact on the addiction process for women.

FREQUENTLY ASKED QUESTIONS ABOUT HOW TO REFER

"How do I bring up referral?"

- let the woman know that you think it would be useful for her to talk with someone knowledgeable about alcohol and/or drug use problems.

- explain your reasons for suggesting a referral; clarify that it is because you are concerned about her well-being.

- be honest with her about her options. Explain that choices in Newfoundland and Labrador are limited. While there are women-only treatment programs in some parts of Canada and the United States, these are limited and not available in all parts of the province. There are female addictions counsellors available through the Alcohol and Drug Dependency Commission and private agencies, as well as women's AA groups in some parts of the province.

"Will my client/patient see my suggestion that she see someone else as a sign of giving up on her or dumping her?"

- Making a referral is neither giving up on a client nor is it dumping her. Help her understand that it is important for her to talk with someone knowledgeable in alcohol/prescription drug problems. You may still be involved with her in your original role. Your support and understanding will surely continue to be important to her.

- Keep in mind that referral is not an unfamiliar concept. It is acceptable within the medical community as a means of receiving specialized care. In most cases this will be perceived in the same manner by your client.

"How should I make the referral? What should I do?"

- Decide with the woman whether she would like to call for an appointment herself, or have you make the call to set up an initial appointment for her.

- Provide her the name, the address, and the phone number of the resource to which you are referring her.

- Discuss with her barriers and problems that must be overcome in availing of the referral services. Make sure she has thought through child care arrangements, family responsibilities, transportation, etc. You

may have to work with her to address these issues even if you feel it is not in your domain. If you do not, the chances of a successful referral may be greatly reduced.

"Is there anything I should do to follow up after making the referral?"

- You may want to make sure that she actually makes the appointment and/or that she shows up for her appointment. One way to demonstrate your concern is to call her before the scheduled appointment and offer words of encouragement and support.

"What do I do if my client agrees to see someone, but there is a waiting period?

- This may be a likely possibility, depending on the services that are available in your area. If there is a need to wait for the services, provide any support that you can. If the situation is one of crisis, consult a specialist in the addictions field and advocate on your client's/patient's behalf.

"Should I refer my client/patient to Alcoholics Anonymous (AA)? If so, is there anything I should know about AA?"

- Alcoholics Anonymous (AA) is a world-wide self-help organization for women and men who have a desire to stop drinking. It is attended regularly by many, and has demonstrated its effectiveness in helping some people overcome their drinking and drug use problems. However, AA is not for everyone. Some women find the organization to be uncomfortable given the preponderance of men and the fact that they are often in the minority at meetings. Many professionals have reservations about sending a woman to AA for this reason.

"If that is the case, is AA really just an organization for men?"

- No, it includes men and women. Approximately one-third of the members in St. John's are women, although the percentage of women is smaller outside St. John's. The number of women attending AA meetings has been growing over the last few years. There is now a women's AA group meeting regularly in St. John's. For information about the AA group nearest you, call the AA Intergroup Office at 579-5215.

"What if she has attended AA before and doesn't want to go?"

- You can't force her to go. However, it is important to know that it is not uncommon for women (and men) to resist returning to AA after previously participating. Acknowledge these previous AA experiences and provide whatever support you can. Not surprisingly, most people feel uncomfortable about attending their first couple of meetings. Many people in AA felt the same way and understand how hard it can be to go the first meeting. Encourage your client/patient to attend in spite of her feelings. Like anything else new, it can be frightening.

"Are there questions my client/patient may ask for which I should be prepared?"

- Yes. Some very common questions include:

Will the meeting really be anonymous?

Yes. One of the principles of A.A. includes, "Who you see here, let it stay here". This means that members do not reveal who attends meetings to others outside of A.A. This is as true in smaller communities with few members as it is in larger communities.

Will it cost anything?

No. There is nothing to pay but a voluntary contribution at each meeting.

Will I have to speak to the group?

No. She will not be expected to speak unless she wants to. A.A. members say there are no "shoulds" or "have to's" in meetings. Members voluntarily share their own strengths and experiences that have worked to keep them sober.

Is there a Women For Sobriety Group?

No. At this point in time there is no WFS group meeting in Newfoundland. WFS is a program of women helping women and is found throughout the world as an alternative to A.A. It is possible to form a group in your area. For additional information, contact:

Women For Sobriety, Inc.
P.O. Box 618
Quakerstown, PA, 18951
Telephone: 215-536-8026

Women for Sobriety
124 Liddell Crescent
Kingston, Ontario K7M 2T5
613-546-1758

WHERE TO REFER: WHAT IS AVAILABLE IN NEWFOUNDLAND

We have discussed the special needs women bring to treatment and the factors that are important in motivating women to avail of treatment. This information is based on the experience and research of women's treatment programs in Canada and other parts of North America. It is important to understand these needs and the services that can best meet them.

A recent report completed for the Health Promotions Branch of Health and Welfare Canada by the Community Services Council of Newfoundland and Labrador, Skirting the Issue: Treatment Needs of Women With Addictions, documented the current status of women's treatment needs in Newfoundland. The research reported that treatment services available to women in Newfoundland are somewhat limited. For example, there are limited addiction treatment programs in Newfoundland that have been designed and run primarily for women. However, women's support groups are occasionally available.

For the most part, women are integrated into general addiction programming. There are relatively few programs that recognize or provide for the needs women specifically bring to the recovery process. At the time of publication of this manual, women who want or need detox services, or treatment in programs that recognize these special needs, must either do it at home or leave the province to receive formal treatment services. In April, 1990, the Alcohol and Drug Dependency Commission assumed responsibility for the operation of Talbot House, a male detoxification centre in St. John's. The Commission plans to take women into Talbot House in the 1991-92 fiscal year. Policies and programs initiatives to accommodate women are now being developed.

There are generally limited resources available in the province for addiction treatment following detoxification. The Alcohol and Drug Dependency Commission provides addiction counselling in five regions around the province

and has recently opened Humberwood, a hospital-based residential addiction treatment service in Corner Brook. Humberwood provides services to women and men. In April, 1991, the Alcohol and Drug Dependency Commission plans to offer the first "all women's group" at Humberwood. If the numbers are sufficient the Commission plans to offer this option on a regular basis.

A list of addiction treatment services currently available in the province follows.

ADDICTION COUNSELLING

1. ALCOHOL AND DRUG DEPENDENCY COMMISSION (ADDC)

The Alcohol and Drug Dependency Commission is the provincial coordinating agency on addictions. The Commission offers addiction counselling on an outpatient basis and includes individual, marital, family and group counselling

Provincial Office Suite 105, Prince Charles Building 120 Torbay Road St. John's, NF A1A 2G8	737-3600 737-3601 (fax)

REGIONAL OFFICES

St. John's Region Suite 105, Prince Charles Building 120 Torbay Road St. John's, NF A1A 2G8	737-3600
Eastern Region (Clarenville) P.O. Box 1614 Masonic Terrace, Marine Drive Clarenville, NF A0E 1J0	466-3663 466-3107 (fax)
Carbonear Field Office	596-3982

Central Region (Grand Falls) 489-3986
11 Hardy Ave. 292-4225 (fax)
P.O. Box 724
Grand Falls, NF
A2A 4L5

Gander Field Office 256-2813

Western Region Office (Corner Brook) 634-4506
(Outpatient Services and Humberwood)
Western Memorial Regional Hospital
P.O.Box 684
Corner Brook, NF
A2H 6G1

Stephenville Region Field Office 643-2269
58 Oregon Drive
P.O. Box 149
Stephenville, NF
A2N 2Y9

Labrador Region 896-5303
167 Hamilton River Rd.
Happy Valley/Goose Bay
Labrador
A0A 1C0

2. DENISE E. LAWLOR AND ASSOCIATES 579-8064
403 Elizabeth Avenue
St. John's, NF
A1B 1V1

Private counselling and Employee Assistance Consultation. Offers addiction counselling which includes individual, couple, family and group counselling. Specific therapy groups for women include Co-Dependency, Women and Addictions, and Sexual Abuse.

SUPPORT GROUPS

1. ACOA (ADULT CHILDREN OF ALCOHOLICS) 739-8962
   44 Cochrane Street 739-4072
   St. John's, NF
   A1C 3L4

ACOA is a self-help program for survivors of alcoholism and/or abuse in childhood.

2. AL-ANON FAMILY GROUPS 579-5215
   323 Hamilton Avenue
   P.O. Box 445, Station C
   St. John's, NF
   A1C 5K4

AL-ANON is a self-help group in several areas of the province offering comfort, hope and friendship to the family and friends of alcoholics.

3. ALCOHOLICS ANONYMOUS (AA) 579-5215
   Central Office 579-6091
   323 Hamilton Avenue
   P.O. Box 445, Station C
   St. John's, NF
   A1C 5K4

AA is a world-wide self-help organization for people with drinking problems. AA groups are located throughout the province. Contact the ADDC office nearest you for specific information or call Central Office, St, John's.

4. NARCOTICS ANONYMOUS (NA)

Narcotics Anonymous is a non-profit fellowship for women and men for whom drugs have become a major problem. Recovering addicts meet regularly to help each other stay "clean." Meetings held Sunday evenings at 8:30 P.M., St. Patrick's Parish Hall, Patrick Street, St. John's.

ALCOHOL AND DRUG ABUSE PROGRAMS FOR NATIVE PEOPLE

1. INNU ALCOHOL PROGRAM 497-8231
   North West River
   Labrador

2. LABRADOR REHABILITATIVE CENTRE 497-8509
   General Delivery
   North West River
   Labrador
   AOP 1M0

Co-ed residential program with holistic approach to recovery; designed to meet specific needs of Inuit and Innu. Non-native clientele welcome when beds permit.

3. LABRADOR INUIT ALCOHOL AND DRUG ABUSE PROGRAM
   North West River 497-8371
   Happy Valley/Goose Bay 896-3396

DETOXIFICATION PROGRAMS

PORT AUX BASQUES

DR. CHARLES L. LEGROW HEALTH CENTRE 695-2151
Detoxification and Education Program

A 5-7 day hospital, inpatient detoxification program. (Primarily men).

ST. JOHN'S

TALBOT HOUSE 778-3557
Deanery Avenue
St. John's,NF
A1E 1H4

A 21-bed, 24-hour unit operated by the Alcohol and Drug Dependency Commission.

OTHER ADDICTION TREATMENT SERVICES

1. HUMBERWOOD CENTRE 634-4506
   Western Memorial Regional Hospital
   Sixth Floor
   P.O. Box 684
   Corner Brook, NF
   A2H 6G1

Humberwood is an inpatient addictions treatment centre, operated by ADDC, for individuals who have a recognized chemical dependency. The program is available to women and men 18 years and older. Referral through regional offices, ADDC.

2. HEALTH SCIENCES COMPLEX 737-6475
   Alcohol Education Program
   300 Prince Philip Drive
   St. John's,NF.
   A1B 3V6

Inpatient or daypatient (psychiatric) treatment designed to assist patients who have been identified as having alcohol abuse problems. Referral by staff psychiatrist.

3. ST. CLARE'S MERCY HOSPITAL 695-2151
   Alcohol Rehabilitation
   188 LeMarchant Road
   St. John's, NF
   A1C 2H8

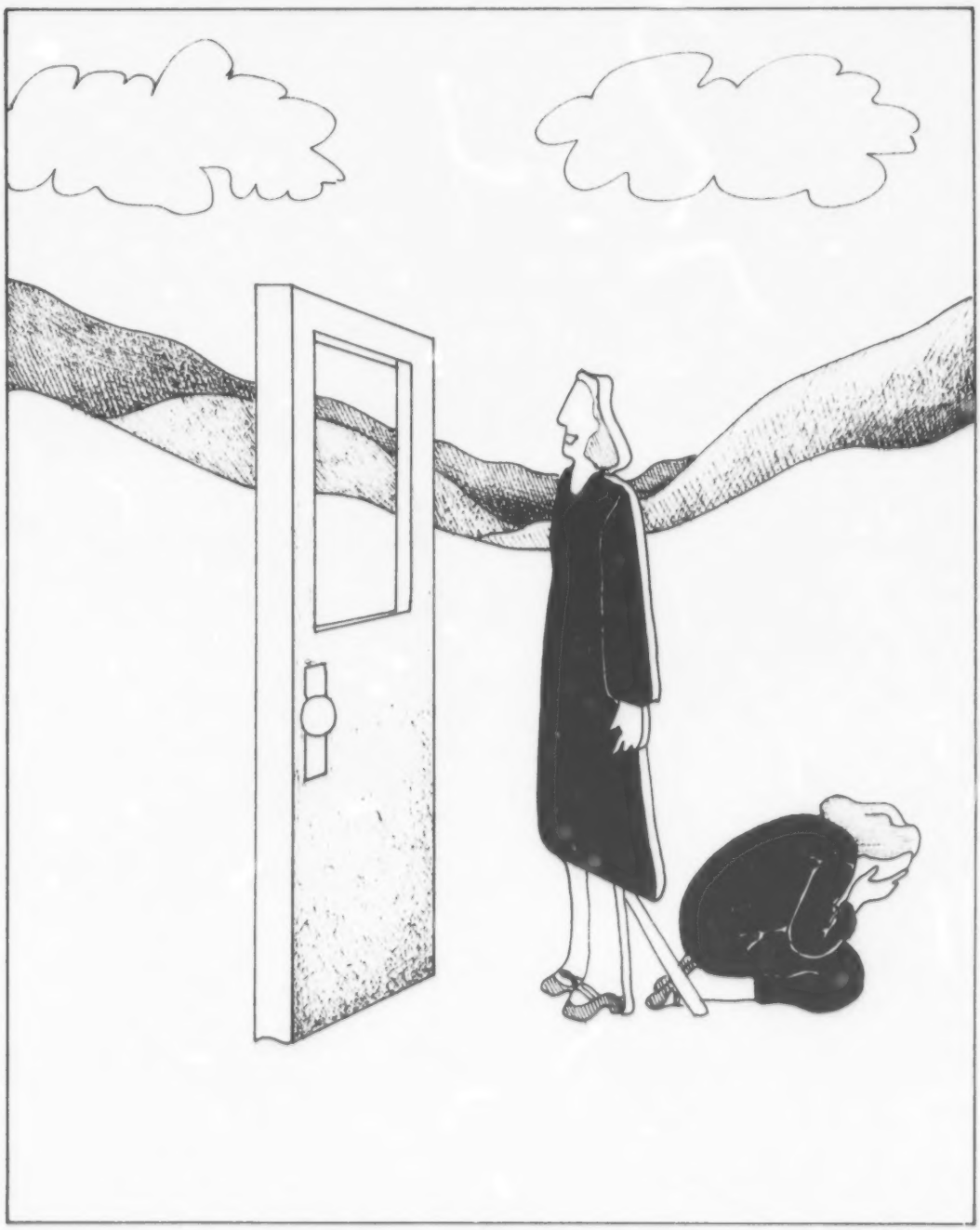
Day treatment focus. Emphasis is on group therapy (both men and women) and follow-up treatment. Referral by staff psychiatrist and employee assistance programs.

4. WATERFORD HOSPITAL ADDICTIONS PROGRAM 364-0322
   Waterford Bridge Road
   St. John's, NF
   A1E 4J8

Outpatient treatment service which offers assistance to individuals who are addicted to drugs or alcohol. Referrals accepted from all inpatient units, the Ambulatory Care Service, Waterford Hospital and from community agencies.

5. SALVATION ARMY HARBOUR LIGHT CENTRE 753-5840
12 Springdale Street
St. John's, NF
A1E 4J8

In-residence, 28-day program for male adults with alcohol dependency.
Community agency and self-referrals accepted.



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Wilsnack, S. "Drinking, Sexuality and Sexual Dysfunctions in Women," Alcohol Problems in Women, (Eds). S. Wilsnack and L. Beckman, New York: Guilford Press, 1984.

Woodland, B., P. Rowe, R. Klein and D. Lawlor. Skirting The Issue: Treatment Needs of Women With Addictions, St. John's: Community Services Council, 1989.

Zankowski, G.L. "Responsive Programming: Meeting Needs of Chemically Dependent Women," Alcoholism Treatment Quarterly, 4 (1987): 53-66.

APPENDIX

CASE STUDIES OF WOMEN WITH ADDICTIONS

The following are three case studies of women with addictions. They are included to help illustrate the type of women who have addiction problems. They also assist in understanding how to approach these women. Each case study presents a brief overview of the woman and her life situation, provides examples of the types of questions a caregiver may ask to determine whether a problem exists, and provides common defences used by women in response to these questions. In all cases, referral to an addiction counsellor or other specialist should be considered if and when substance abuse emerges as an issue.

CASE #1

Penny, a single mother with two pre-school children talks with you about an ex-husband who is providing no support. She talks desperately about trying to make "ends meet", yet feels very angry inside. There is no one to take care of her needs. She has no one to talk to. Sometimes she feels like she should just "end it all". The pressure can't go on!

Her own family provides little support. Her father is an alcoholic and her mother just "puts up with it". Their philosophy is that "you made your bed and you lie in it". Penny admits that she got married just to leave the home. Now, it seems she has a new set of problems to handle which are just as unbearable.

Caregiver's Role

You start where Penny feels comfortable, allowing her time to talk about her feelings and the fact that she wants a better life for her children and herself. She is having a difficult time coping with all the pressures of single parenthood

in addition to being an adult child of an alcoholic. Some specific questions that need to be asked include:

- What do you do to unwind? to relax? to have fun?
- How do you cope with all the pressures of home life?
- How did you feel growing up in an alcoholic home?
- How do you feel about your Dad?
- Do you take medications as a means of coping?
- Do you use alcohol or other chemicals?
- What was your ex-husband like? Why did you separate?
- What supports do you have to help you during this time?

The most important thing is to focus on the fact that Penny has come to get help. The pressures and problems of being a single parent need to be discussed, as do her means for coping with them. In addition, education about addictions and about co-dependency and adult children of alcoholics would help Penny understand how these impact on her life and how she can work to change the cycle. This information may be provided by an addictions counsellor or through the Alcohol and Drug Dependency Commission.

Some Common Defences

1. *"I need medications to cope. My doctor prescribed them because he knows I am under a great deal of pressure. It is my only hope".*

   Medications are only temporary answers to problems. Finding other ways of handling the pressures of single parenting requires that Penny get help to learn effective ways of managing her life. Stress management, assertiveness training, financial budgeting, exercise, weight control, nutrition, and parent effectiveness are all effective choices.

2. *"Having a few drinks is my only way to unwind. I just can't afford to socialize outside my home".*

   There is really no harm in having a few drinks, but Penny must be honest with herself. What is "a few drinks"? How often does she drink? How can she cope with feelings of loneliness in other ways? Drinking at home alone after the kids are in bed poses the risk of having other problems. The risk is compounded by the fact that Penny is an adult child of an alcoholic.

3. *"Are you saying I am an alcoholic?"*

   No. But the risk exists. If Penny continues to use alcohol or other drugs as a way of coping with her problems, she can develop a chemical dependency. Chemical dependency or addiction means that she has a problem that requires professional help. It is much better to start looking at how she uses alcohol and other drugs now than waiting until she has a problem with it. Penny needs to be especially cautious given the fact that she is the adult child of an alcoholic.

4. *"All my friends use medication and alcohol to unwind. What's the problem?"*

   Just because Penny's friends use medication and alcohol to relax and unwind does not mean it is good for them. Many people never question why; instead they just do like everybody else. We all need to be educated and aware of the possible harmful effects of misusing medications and alcohol.

CASE #2

Jody comes to get help for her husband. Her husband has started drinking again. She knows that the drinking is affecting the whole family. Her nerves are shot! She is taking some tranquillizers to calm her nerves. How can she help him stop drinking?

Caregiver's Role

Jody is attempting to cope with an alcoholic spouse, yet in the process her husband's drinking is adversely affecting her. She has become co-dependent and lives her life trying to save her husband. In the process she has forgotten to meet her needs and take care of herself. Some important questions that need to be asked:

- Do you worry about your husband's drinking?
- Do you tell lies to cover up for his drinking?
- What is it like at home when your husband is not drinking?
- What is it like at home when your husband is drinking?
- Do you feel that if your husband loved you he would stop drinking to please you?
- Do you drink as a way of coping with his drinking?
- Do you take medications to cope with your situation?
- Do you feel that there is no one who understands your problems?
- What supports do you have to help you?

Some Common Defences

1. *"I only take medications when I am really stressed out".*

   Taking medications to cope with stress is only a temporary solution. Learning new, positive ways of handling stress means not becoming dependent on drugs when a crisis erupts at home.

2. *"I am not an addict. My husband is the one that has the problem".*

   When you live with a spouse who abuses alcohol you become part of the problem too. You begin to take responsibility for his problem and learn to react to his drinking. You become co-dependent and enable the process by protecting the alcoholic. Often times, your own needs are not met. Jody needs to learn to take care of her own needs as the first step in her own recovery process. Her husband has to begin to work on his own problems. She can assist in this process by encouraging him but it must be his decision to get help for himself.

CASE #3

Mary, age 45 years, has been married for 10 years. She comes to you and discusses problems of marital dysfunction, and a spouse who doesn't trust her. She has had several drinking sprees in the past month. On all three occasions she experienced blackouts and could not remember what she did in the company of friends and strangers. She was too embarrassed to ask. Her husband does not believe she is an alcoholic; just that she sometimes drinks too much. He feels that she has to learn how to handle her drinking. To him, it is a matter of self-control. Mary is not so sure. All she knows is that drinking is causing her problems. What should she do?

Caregiver's Role

It is vital to start "where Mary is at" and attempt to clarify what she thinks is her problem. Also, it is important to provide her with some information on addictions. Some specific questions that the caregiver could ask:

- What, in your view, is an alcoholic?
- How is alcohol affecting your life?
- Is your husband receptive to talking about your drinking?
- How is your drinking affecting your relationship?
- Is there a family history of alcohol or drug abuse?
- What changes would you like to make in your life right now?

The most important thing to focus on is that Mary has come to you for help. Focus on the positive. She has made the first step in looking at herself. Education on what alcohol addiction or problem drinking means needs to be addressed. It is vital for Mary to know that having a problem with alcohol means that alcohol is beginning to impact on her life in negative ways. The alcohol begins to take control of her life instead of her taking control of it. The first step in taking back control is for her to stop drinking. Reinforce that this is

not easy. In order to stop drinking Mary is going to have to have support to help her. One support can be you, although you should not hesitate to refer Mary to a specialist in the treatment of alcohol and drug dependency.

Some Common Defences

1. *"Sure, I can stop drinking. Then all my problems will be solved, right?"*

   Giving up alcohol is the first step. This takes time and lots of support. After giving up alcohol, Mary must make new life changes that require giving up old patterns of living. Recovery is a life-long process that requires lots of help. When you make a change in your life, it impacts on everyone around you (i.e., family, friends).

2. *"My husband will never understand. He drinks and has his few beer. He thinks I'm crazy to see someone about a problem that I should solve myself."*

   Asking Mary what she thinks will help her is the first step. Learning how to deal with her husband is another challenge. Encourage her to talk to her husband and let him know that she feels she needs help for her problem. At the same time, this problem impacts on the whole family. Therefore, any changes she makes will affect the whole family. Having support from her husband will help make the transition a little easier.

   Ask Mary about her biggest fear. If she is afraid that her husband will not understand her problem or support her, these fears may need to be addressed. When Mary is ready, she may need to decide what is best for her: meeting her needs with the support of her husband or just doing it on her own.

3. *"Can I ever be a social drinker again?"*

   This is a difficult question to answer. If Mary is addicted to alcohol and cannot control it, it is unlikely that she can ever resume social drinking. Instead, she must be aware of the possibility that drinking will always present a problem for her. She must find new ways of coping with her life and begin to feel comfortable with saying "no" to alcohol.

4. *"My problem is not that serious. I only drink on weekends and I have only had three blackouts. That's not too serious, is it?"*

   Every woman has to decide for herself the quality of life that she wants and feels that she deserves. Having blackouts is a sign that Mary is developing a physical dependence on alcohol. Every time she drinks, she is taking the risk of causing more damage to her body and her emotional health. The choice is hers to make.

FOR MORE INFORMATION

SELECTED RESOURCE/TREATMENT SERVICES

NEWFOUNDLAND

Alcohol and Drug Dependency Commission (ADDC)
Suite 105, Prince Charles Building
120 Torbay Rd.
St. John's, NF A1A 2G8
(709) 737-3600

NOVA SCOTIA

Women's Clinical Resource Centre
Nova Scotia Commission on Drug Dependency
5675 Spring Garden Road
Halifax, NS B3J 1H1
(902) 424-7264/424-7214

PRINCE EDWARD ISLAND

Queens County Addiction Services
McGill Ave
Charlottetown, PEI C1A 7N5
(902) 368-4120

ONTARIO

Addiction Research Foundation (ARF)
33 Russell Street
Toronto, ON M5S 2S1
(416) 595-6111

Addiction Assessment Care & Treatment Services
Waterloo Region
33 Jackson Avenue
Kitchener, ON N2H 3N7
(519) 744-1351

ONTARIO, Continued

The Amethyst Women's Addiction Centre
488 Wilbrod Street
Ottawa, ON K1N 5M6
(613) 563-0363

Aurora Community Women's Alcohol
and Drug Treatment Program
81 Eastchester Avenue
Box 633
St. Catherines, ON L2R 6W8
(416) 685-5425

Bellwood Health Services
1020 McNicoll Avenue
Scarborough, ON M1W 2J6
(416) 495-0926

Clarissa Manor Recovery Home
Kenora Fellowship Centre
208 Water Street
Kenora, ON P9N 1S4
(807) 468-5530

Donwood Institute
175 Brentcliffe Rd.
Toronto, ON M4G 3Zl
(416) 425-3930

Empathy House
360 Sunnyside Avenue
Ottawa, ON K1S OS4
(613) 232-7319

Jean Tweed Centre
3131 Lakeshore Blvd. West
Toronto, ON M8V 1K8
(416) 255-7359

ONTARIO, Continued

Homes for Reflection
141 Niagara Street
Welland, ON L3C 1J4
(416) 735-4042

Women for Sobriety
124 Liddell Crescent
Kingston, ON K7M 2T5
(613) 546-1758

ALBERTA

Henwood Treatment Program
Box 100, R.R. 6
Edmonton, Alberta T5B 4K3
(403) 973-3341

OTHER

Women's Alcoholism Program of CASPAR
6 Camelia Ave.
Cambridge, MA 02139
(617) 661-1316

SELECTED RESOURCES

DIRECTORIES

Directory of Treatment Services in Newfoundland and Labrador. Available from Alcohol & Drug Dependency Commission, Nfld. and Lab. Suite 105, Prince Charles Building, Torbay Road, St. John's, Nfld. A1A 2G8.

Directory of Alcohol & Drug Treatment Resources in Ontario. Addiction Research Foundation, Toronto. Catherine Blake (Ed.) 1985.

Directory of Facilities and Services for Gay/Lesbian Alcoholics. Available from 204 West 20th Street, New York, New York 10011.

I Am Worth The Effort. A Handbook for Women In Abusive Relationships. Judith Kelsey. Produced for: Iris Kirby House (St, John's Transition House), P.O. Box 6208, St. John's, Newfoundland, A1C 6J9. Includes provincial directory of organizations that may support women's needs.

TREATMENT INFORMATION

It's Just Your Nerves - A Resource on Women's Use of Minor Tranquillizers and Alcohol Guidebook. Health Promotion Directorate, Health Services and Promotion Branch. Ottawa: Minister of National Health and Welfare, 1982. Catalogue H39-119/ 1988E).

Getting Sober, Getting Well.- A Treatment Guide for Caregivers Who Work With Women. Norma Finkelstein, Sally A. Duncan, Laura Derman, Janet Smeltz. Cambridge, MA: Women's Alcoholism Program of CASPAR, 1990.

Women and Addiction Module - The Women's Working Group, Manitoba. Available from Donwood Institute, Ms. Doreen Birchmore.

Women and Addiction: A Resource Kit. Health Promotion Directorate, Health Services and Promotion Branch. Ottawa: Minister of National Health and Welfare, Health and Welfare, Canada, 1978.

A Women's Group: The Issues, Rationale and Structure. Kathleen Finlay, Doreen Birchmore and Janet Dowling. Ottawa: Health and Welfare Canada.

Treating Alcoholic Women - A Resource Book. Developed by The National Centre for Alcohol Education, N.I.A.A.A. Rockville, MD: Government Printing Office, 1979.

Chemical Dependency and Violence: Working With Dually Affected Families - A Cross Training Manual for Counsellors and Advocates. Janet M. Wright, 1982. (Available from the Toronto's Women's Bookstore.)

Skirting The Issue. Treatment Needs of Women With Addictions. Bonnie Woodland. St. John's: Community Services Council, 1989.

SELF-HELP

Helping You Helps Me. A Guide Book for Self-Help Groups. Karen Hill. Social Service Programs Branch, Health and Welfare Canada. Canadian Council on Social Development, P.O. Box 3505, Ottawa, Ontario, K1Y 4G1

BOOKS

Alcohol Dependency

Alcohol and Drug Dependent Women. Sheila Blume. Minneapolis: Johnson Institute, 1985.

Alcohol in Canada. Marc Eliany (ed.), Ottawa: Health and Welfare Canada, 1989.

Alcohol is A Women's Issue: A National Conference and Call to Action. New York: National Council on Alcoholism, 1989.

The Chemically Dependent Woman: Recognition, Referral and Rehabilitation (Proceedings of a Conference sponsored by the Donwood Institute). Janet Dowling and Anne MacLennan (ed) Toronto: Addiction Research Foundation, 1978.

Goodbye Hangovers, Hello Life: Self Help for Women. Jean Kirkpatrick. New York: Ballantine, 1986.

Loosening The Grip. A Handbook of Alcohol Information. Jean Kinney, Gwen Leaton. Saint Louis: C.V. Mosby Company, 1987.

Say When: Everything A Woman Needs to Know About Alcohol and Drinking Problems. Rosemary Kent. London: Sheldon Press, 1989.

A Woman Like You: Life Stories of Women Recovering from Alcoholism and Addiction. V. Rachel. New York: Harper & Row, 1985.

Women and Alcohol: A Dangerous Pleasure. Geraldine Youcha. New York: Crown Publishing, 1986.

Women and Alcohol: Health Related Issues. National Institute on Alcohol Abuse and Alcoholism. Washington: U.S. Dept. of Health and Human Services, 1986.

Women In Treatment: Creating A New Self Image. Barbara McFarland. Centre City, MN.: Hazelden, 1984.

Women Who Drink. Alcoholic Experience and Psychotherapy. Vasanti Burtle. Springfield IL.: Charles C. Thomas, 1979.

Drug Dependency

Drugs and Women. Paul Hardstrom August. New York: Chelsea House, 1987.

Licit and Illicit Drugs in Canada. Marc Eliany (ed.), Ottawa: Health and Welfare Canada, 1989.

Women and Cocaine: Personal Stories of Addiction and Recovery. Vicki D. Greenleaf. Los Angeles: Lowell House, 1989.

Women and Drugs: Getting Hooked, Getting Clean. E. Peluso, L. Silvay Peluso. Minneapolis: Compcare Publishers, 1988.

FILMS ABOUT WOMEN AND ADDICTIONS

* available from the Alcohol and Drug Dependency Commission of Newfoundland and Labrador

** available from the Women's Clinical Resource Centre, Nova Scotia Commission on Drug Dependency

*** available from the Addiction Research Foundation in Toronto

Title: **ALCOHOL, DRUGS AND SENIORS: TARNISHED DREAMS****
Year: 1986
Medium: 1/2" VHS Video Cassette
Length: 23 minutes
Synopsis: John Astin is the narrator of this contemporary video which shows how the use of alcohol and prescription drugs affects the lives of elderly people.

Title: **AN EASY PILL TO SWALLOW*/*****
Year: 1978
Medium: Film
Length: 28 minutes
Synopsis: Many of those who are prescribed tranquillizers are women who go to their doctor with unspecified symptoms and are given tranquillizers to make them feel better. Several women tell how they became addicted to tranquillizers and discuss the problems they experienced when trying to stop their use of pills.

Title: **BORN DRUNK: THE FETAL ALCOHOL SYNDROME***
Year: 1979
Medium: Film
Length: 10 minutes
Synopsis: This film shows the effects of Fetal Alcohol Syndrome (FAS) on newborn children.

Title: **THE BOTTOM LINE: WOMEN AND ALCOHOL*****
Year: 1982
Medium: 1/2" VHS Video Cassette
Length: 28 minutes
Synopsis: Women alcoholics, social drinkers, treatment people, and a researcher candidly describe on camera the problems faced by

women. The videotape explores survival techniques developed by women in respect to alcohol use and abuse.

Title: **CALLING THE SHOTS**
Year: 1983
Medium: Film
Length: 30 minutes
Synopsis: This film shows how some advertising deliberately disguises the warning signs of problem drinking and falsely links alcohol with happiness, success, sexual fulfilment, prestige, athletic ability, and creativity.
(Cambridge Documentary Films, 617-354-3677)

Title: **DEBBY AND SHARON - RECOVERY SERIES*****
Year: 1985
Medium: Film
Length: 15 minutes
Synopsis: Debby and Sharon are sisters who grew up in an alcoholic family and have had problems with alcohol themselves. They have also had problems with their own families. Both have been sober for awhile and are now taking a greater interest in their native Indian culture.

Title: **DELIA - RECOVERY SERIES*****
Year: 1985
Medium: Film
Length: 12 minutes
Synopsis: Delia is a health-care professional and a single parent. The film looks at her use patterns and shows how her friends finally persuaded her to get help herself. Although she has completed a treatment programme, she is still having difficulty.

Title: **THE ENABLERS****
Year: 1978
Medium: 1/2" VHS Video Cassette
Length: 23 minutes
Synopsis: Jan is a wife, mother, career woman, and alcoholic. This video demonstrates the ways in which her family, friends, and co-workers enable the progression of her alcoholism.

Title: **FAMILY MATTERS****
Year:
Medium: 1/2" VHS Video Cassette
Length: 30 minutes
Synopsis: This video profiles five families with various forms of addiction.

Title: **FETAL ALCOHOL SYNDROME***
Year: 1985
Medium: 1/2" VHS Video Cassette
Length: 1985
Synopsis: Mary, a mother of five, shares her experiences with alcohol and its effect on her children and her life.

Title: **FETAL ALCOHOL SYNDROME: "HERE'S TO BABY"***
Year: 1984
Medium: 90 Slides and Audiotape
Length:
Synopsis: This presentation provides a general overview of the effects of alcohol on the unborn fetus.

Title: **FRANCESCA BABY - PART I**
Year: 1976
Medium: Film
Length: 22 minutes
Syncpsis: Illustrates the effects of alcoholism on a family. In this film the mother is as alcoholic. The father, a travelling salesman, avoids confronting the problems of his wife's disease. The burden of the mother's disease falls on the two children, Kate 10, and Francesca 17. (Coronet MTI, Deerfield, IL, 800-621-2131)

Title: **FRANCESCA BABY - PART II**
Year: 1976
Medium: Film
Length: 25 minutes
Synopsis: Francesca receives a pamphlet from Alateen sent anonymously. Reluctantly, she attends a meeting where she discovers several classmates are members. Alateen gives her new insight, and she and Kate take steps to protect their lives against their mother's erratic behaviour. In a series of dramatic events, the girls finally establish a line of communication with their mother.
(Coronet MTI, Deerfield, IL, 800-621-2131)

Title: **INNOCENT ADDICTS****
Year:
Medium: 1/2" VHS Video Cassette
Length: 29 minutes
Synopsis: The true stories of twelve mothers recovering from substance abuse are a background for an investigation of the issues surrounding drug use in pregnancy. The video looks at emotional and physical side effects on mother and child and explores recovery and rehabilitation.

Title: **THE INTERVENTION****
Year: 1978
Medium: 1/2" VHS Video Cassette
Length: 28 minutes
Synopsis: This video, a sequel to **THE ENABLERS**, realistically shows the problems, possible results and rewards of intervention with a female alcoholic.

Title: **JOURNEY THROUGH DARKNESS INTO LIGHT****
Year: 1988
Medium: 1/2" VHS Video Cassette
Length: 57 minutes
Synopsis: In a series of interviews, four women describe the stages of the journey from alcoholism to recovery, with personal stories that provide an anecdotal map of the route. Their tales are compelling and inspiring. Alcoholism for them was a catalyst for inner growth and transformation.

Title: **THE LAST TO KNOW*****
Year: 1981
Medium: Film
Length: 28 minutes
Synopsis: This film focuses on the "special" problems of women's health in terms of alcohol and drug abuse. Four women, whose lives have been affected by alcohol, prescription drugs and/or street drugs, are interviewed. Their accounts of the factors contributing to their problems reveal how physicians, the media, and society view the woman alcoholic. Film inserts of advertising relating to alcohol and drugs exemplify these issues, while interviews with the "man on the street" suggest that there is a misunderstanding on the part of society regarding the problem of women and addictions.

Title: **LISA: LEGACY OF SANDRA BLAIN*****
Year: 1979
Medium: Film
Length: 23 minutes
Synopsis: After her mother's death, Lisa, unable to deal with her grief, becomes isolated from everyone and starts to drink heavily. Her mother had been an alcoholic, but Lisa wants to believe that she is different and does not have a problem. Her drinking begins to have an effect on her work performance and her boyfriend ends their relationship. These situations lead to further drinking and taking pills resulting in an overdose. A co-worker takes Lisa to the hospital and later helps her start a rehabilitation program. Lisa learns that she can deal with her problems without alcohol.

Title: **LORI - RECOVERY SERIES*****
Year: 1985
Medium: Film
Length: 14 minutes
Synopsis: Lori, a lesbian, is interviewed about her past drinking and her treatment. After many years, she admitted herself to a psychiatric ward where she suffered such severe withdrawal that she realized she needed more treatment. At a women's treatment centre she learned how to restructure her life and has now been sober for five years.

Title: **NEW BEGINNINGS: WOMEN, ALCOHOL AND RECOVERY**
Year: 1977
Medium: Film
Length: 20 minutes
Synopsis: This film allows the viewer to share in the actual recovery of three women in their natural settings of home, recreation, and work. Featured are a young woman recovering from alcohol and drug abuse; a sensitive, compelling Black woman (author of I'm Black and I'm Sober; and a silver-haired career woman and grandmother. (Aims Media, Inc., Van Nuys, CA, 800-367-2467)

Title: **THE NEW LIFE OF SANDRA BLAIN*****
Year: 1976
Medium: Film
Length: 27 minutes
Synopsis: In reply to a phone call for help from a woman who has difficulties in quitting drinking, Sandra recalls her own drinking days when she lost her husband and children and ended up in a

rehabilitation home. When the court denies her suit to regain her children she feels defeated and begins drinking again. Her work suffers and her drinking becomes heavier. Finally, she is forced to get help and rejoins her therapy group.

Title: **ONE FOR MY BABY****
Year: 1982
Medium: 1/2" VHS Video Cassette
Length: 30 Minutes
Synopsis: This television documentary shows the historical and cultural influences which perpetuate drinking during pregnancy. It investigates the human and medical aspects of Fetal Alcohol Syndrome.

Title: **PANDORA'S BOTTLE: THE DRINKING WOMAN****
Year: 1981
Medium: 1/2" VHS Video Cassette
Length: 40 minutes
Synopsis: Mariette Hartley shows through interviews and dramatizations the ways in which society views female alcoholics differently from male alcoholics.

Title: **PREGNANCY: OUR CHOICE...THEIR FUTURE***
Year: 1984
Medium: Film
Length: 20 minutes
Synopsis: This film explains how a mother can prevent her baby from being born with drug and alcohol induced problems.

Title: **THE RECOVERY SERIES****
Year: 1985
Medium: 1/2" VHS Video Cassette
Length: 55 minutes
Synopsis: In four interviews, a lesbian, a career woman, a former prostitute, and two native women realistically share their stories of addiction to alcohol and other drugs.

Title: **RUTH - RECOVERY SERIES*****
Year: 1985
Medium: Film
Length: 13 minutes

Synopsis: Ruth had used heroin, alcohol, and prescription drugs. She had tried to get off drugs on her own and suffered severe withdrawal. Following treatment she is taking care of herself and not blaming others for her problems.

Title: **THE SECRET LOVE OF SANDRA BLAIN***
Year: 1971
Medium: Film
Length: 27 minutes
Synopsis: This film tells the story of a middle class housewife who drinks at home in secret.

Title: **TRICK OR DRINK****
Year: 1985
Medium: 1/2" VHS Video Cassette
Length: 20 minutes
Synopsis: This video, which discusses alcoholism and bulimia, depicts a young girl's life in an alcoholic home. It provides insight into the social and psychological problems which beset adult children of alcoholics.

Title: **TURNAROUND: A STORY OF RECOVERY****
Year: 1982
Medium: 1/2" Video Cassette
Length: 46 minutes
Synopsis: Filmed at a residential treatment centre for chemically dependent females in Vancouver, this video shows women as they learn to address and handle their addictions.

Title: **UNLIKELY ADDICTS: MIDDLE CLASS WOMEN**
Year: 1981
Medium: Film
Length: 29 minutes
Synopsis: Journalist Barbara Kerr discusses private and public addicts. Private addicts are often housewives who often find their lives are not fulfilling. They attempt to keep their addictions secret and usually become dependent on alcohol and/or barbiturates. (PBS Video, 202-488-5220)

Title: **WOMEN AND ALCOHOL: THROUGH THE DRINKING GLASS*****
Year: 1980
Medium: Film
Length: 27 minutes
Synopsis: Carol Burnett narrates this film about the problem of alcoholism and women. She speaks of the pervasiveness of the problem, of the many factors that contribute to its development, and of its dramatic consequences. Four recovering alcoholic women speak of their individual experiences and show that it is possible to recover and start a new life.

Title: **WOMEN AND THEIR USE OF MOOD-ALTERING DRUGS: THE IMMIGRANT EXPERIENCE*****
Year: 1984
Medium: 1/2" VHS Video Cassette
Length: 16 minutes
Synopsis: This tape presents some of the stresses that immigrants, particularly women, may have to face in adjusting to a new society. The program shows some of the short and long term effects of using minor tranquillizers as a way of coping.

Title: **WOMEN, DRUGS, AND ALCOHOL**
Year: 1980
Medium: Film
Length: 21 minutes
Synopsis: This film emphasizes the problems that can occur with the use of prescription drugs and/or alcohol. Through interviews, the film points out that frequently the physician is treating only the symptoms and not the causes of the problem when prescribing psychoactive drugs to women.
(MIT Teleprograms, Northbrook, IL, 800-323-5343)

Title: **WOMEN IN RECOVERY**
Year: 1987
Medium: Film/Video
Length: 50 minutes
Synopsis: This film looks at the diverse population of women seeking substance abuse services, as well as addressing the interrelated issues that women often experience in conjunction with their substance use. The video highlights the lives of three women: a woman of colour, a lesbian, and a single parent. They discuss their lives, chemical use, and recoveries.
(Chrysalis, A Centre for Women, 612-871-0118)

FILM INDEX

TOPIC	FILM TITLE
Alcohol and Alcoholism	Alcohol, Drugs and Senior
	The Bottom Line
	Debby and Sharon - Recovery Series
	Delia - Recovery Series
	The Enablers
	Family Matters
	Francesca Baby - Part I
	Francesca Baby - Part II
	Innocent Addicts
	Journey Through Darkness into Light
	The Last to Know
	Lisa: Legacy of Sandra Blain
	Lori - Recovery Series
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	Trick or Drink
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	Women and Alcohol: Through the Drinking Glass
	Women, Drugs, and Alcohol
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Co-Dependency	The Enablers
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	The Last to Know

TOPIC	FILM TITLE
Fetal Alcohol Syndrome	Born Drunk
	Fetal Alcohol Syndrome
	Fetal Alcohol Syndrome: Here's to Baby
	Innocent Addicts
	Pregnancy: Our Choice...Their Future
Illicit Drugs	Family Matters
	Innocent Addicts
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Natives	Debby and Sharon - Recovery Series
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	An Easy Pill to Swallow
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	Innocent Addicts
	Journey Through Darkness Into Light
	The Last to Know
	Lisa: Legacy of Sandra Blain
	New Beginnings
	The Recovery Series
	Unlikely Addicts
	Women and Their Use of Mood Altering Drugs
	Women, Drugs, and Alcohol
	Women in Recovery
Recovery/Treatment	Debby and Sharon - Recovery Series
	Delia - Recovery Series
	Innocent Addicts
	The Intervention
	Lisa: Legacy of Sandra Blain
	Lori - Recovery Series
	New Beginnings
	The New Life of Sandra Blain
	The Recovery Series
	Turnaround: A Story of Recovery
	Women and Alcohol: Through the Drinking Glass
	Women in Recovery

GLOSSARY

Addiction

Addiction is a term used to describe drug dependency. It refers to the compulsion to take alcohol and/or other drugs in order to experience their psychological and physical effects and/or to avoid the discomfort of their absence.

Alcohol Problems

There is no universally agreed upon dividing line between safe and hazardous drinking. Under some circumstances, relatively low levels of alcohol consumption can produce problems for individuals. Increasing quantities of intake will increase the risk of problems relating to physical, emotional and social health. There has been a tendency to replace the stigmatized term "alcoholism" with that of "alcohol dependence" or alcohol problem.

Co-Dependency

Co-dependency refers to the patterns of coping by people who are affected by someone else's drinking or substance abuse. Other words to describe the pattern are co-alcoholic and enabler.

Cross-Addiction

Cross-addiction is a term to define the physical and psychological dependence on alcohol and another drug with similar pharmacology. Because of their similar pharmacology they are also virtually interchangeable. Cross-addiction is also referred to as cross-dependence or polydrug abuse.

Cross-Tolerance

Cross-tolerance is the increase in need for either one or both substances in order to maintain the same effect. One can substitute one drug for the other, yet with continued use more of the drug is needed to achieve the same effect.

Prolonged use may diminish the effect of the same level of either or both substances.

Drug Abuse

Drug abuse is defined as acute or chronic intake of any chemical other than alcohol that has no recognized medical use, or which has an accepted medical use but is used improperly in terms of application or dose. Reference is generally to psychoactive drugs.

Drug Dependence

Drug dependence can be psychological and/or physical, and may develop as a result of chronic drug abuse.

Enabler

An enabler is someone close to an addicted woman who unconsciously helps her to continue to drink or abuse drugs and protects her from the consequences. Enablers deny the addicted woman's problems, or minimize or rationalize the behaviour. They will blame, criticize, and take over the responsibility of the addicted woman. The enabler may feel anger and guilt, which stem from the fact that they are unable to control the addicted woman.

Physical Drug Dependence

Physical drug dependence is a physiological state of adaptation to a drug. Dependence exists when the body becomes so accustomed to a particular drug that it can only function normally if the drug is present. Without the drug, the user may experience withdrawal symptoms ranging from mild discomfort to convulsions.

Poly-Drug Abuse

Poly-drug abuse means dependence on more than one drug.

Psychological Drug Dependence

Psychological drug dependence is indicated by a feeling of satisfaction associated with use of the drug, or a psychic craving for the drug and its effects. The drug is so central to a person's thoughts, emotions, and activities, that it is very difficult to stop using it or to stop thinking about it. Psychological dependence is a contributing cause of persistent drug use.

Tolerance

Tolerance is a phenomenon in which increasing doses of a drug are needed in order to have the same effect. It is commonly observed with the intake of narcotics, alcohol, barbiturates and benzodiazepines.

Withdrawal

Alcohol is an addictive drug. Thus, taken in sufficient quantities, the body becomes adapted or accustomed to its presence. If consumption is curtailed after physical dependence is established, there will be symptoms of withdrawal. Some withdrawal symptoms are tremors or shakes, hallucinations, seizures, and delirium tremens (DT's).